CONDUCTING THE ORCHESTRA IN AGED CARE: THE LEADERSHIP ROLE OF THE REGISTERED NURSE

A Thesis submitted by

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clinical leadership, leadership, registered nurse, residential aged care, distributed leadership, communication, structural empowerment, Kanter

Abstract

The registered nurse (RN) position in the residential aged care setting is a role that encompasses the position of care coordinator, staff liaison and educator and one that orchestrates the direction of care of residents. This research is grounded in interpretive phenomenology. The philosophical and methodological grounding and structure of the research draws on the tenets of Hans George Gadamer's premise of hermeneutic phenomenology. This premise guides the research in an exploration of the 'what is' of the leadership role of the RN working in residential aged care environments. Interviews were conducted with registered and enrolled nurses and unregulated health care workers and equated to the thirteen clinical care staff participants from across two states in Australia in four aged care settings.

The study suggests that the leadership role of the RN was identified as a fine balance between the leading, sometimes following and at other times the silent observer available and willing to intervene or converse when the time was seen as right. The study identified that RN leadership was a multidimensional phenomenon. Two key areas appeared in the leadership role, identified as the understanding of the leadership role and the application of leadership in practice. The realisation of how the understanding and the application of the RN leadership role were perceived and received by aged care staff was important. The RN sets the scene, coordinates the care and engages other staff in the unified practice of caring under the auspices of their leadership role.

The implications for the residential aged care sector is seen in the leadership enacted by the RN, the missed opportunities or the capacity of the RNs employed in the sector to both have a voice, an understanding and an ability to practically apply the leadership required. It was the difference or indifference seen, heard and expressed through the clinical care staff participants that created the dissonance or consonance in leadership expressed by those working in the setting. The research has identified clinical leadership as a key component in the understanding and application of leadership by the RN in the residential aged care setting. To enable this in practice the RN requires education for leadership in practice, rather than leadership by style or characteristic.

Certification of Thesis

This thesis is entirely the work of *Melissa Taylor* except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Student and supervisors' signatures of endorsement are held at USQ.

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List of Abbreviations

The following abbreviations have been used in the pages contained in this thesis.

ABS	Australian Bureau of Statistics
ACFI	Aged Care Funding Instrument
AHPRA	Australian Health Practitioners Regulation Authority
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in Nursing
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
DOH	Department of Health
EN	Enrolled Nurse
EEN	Endorsed Enrolled Nurse
HWA	Health Workforce Australia
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse Practitioner
PCA	Personal Care Attendant
RN	Registered Nurse
UHCW	Unregulated Health Care Worker
UN	United Nations
WHO	World Health Organisation

Chapter 1: Introduction

Selecting the Melody

'As leaders, we play a crucial role in selecting the melody, setting the tempo, establishing the key, and inviting the players. But that is all we can do. The music comes from something we cannot direct, from a unified whole created among the players—a relational holism that transcends separateness. In the end, when it works, we sit back, amazed and grateful.'

—Wheatley (1993, p. 44)

1.1 INTRODUCTION

The role of the registered nurse (RN) in residential aged care settings is expansive. RN employment numbers are limited, their practice is regulated and controlled, and yet, the desire by RN's to achieve quality resident outcomes is at the fore. This research is about exploring the 'what is' of the leadership role of the RN working in residential aged care environments. The overall responsibility and accountability for care is both recognised and enacted through the leadership role of the RN in this setting. The RN sets the scene, coordinates the care and engages other staff in the unified practice of caring under the auspices of their leadership role.

Understanding this definition of RN leadership in aged care encompasses many layers of complexity. The realisation of how the understanding and the application of the RN leadership role are perceived and received by aged care staff is important. Providing leadership as an RN to aged care staff, many of whom are unregulated health care workers (UHCW), adds a further dimension to the complexity of the role. Recognising and articulating this experience and being able to define and demonstrate this in practice has not been clearly articulated and understood. This thesis presents an account of the narrative of the leadership role of the RN in the residential aged care setting. The analogy of the workings of an orchestra has been used to reveal the voices of the staff in the aged care context. It is leadership that contributes to staff and resident satisfaction, to good resident outcomes and to a state of contentment and agreement within a team and its broader construct.

This chapter introduces the research (section 1.1; 1.2; 1.3) along with outlining the research question (section 1.4) and aim (section 1.5) and the research design and methodologies (section 1.6). Section 1.7 discusses the phenomena of interest, along with the research setting (section 1.8) and the research justification (section 1.9) is discussed with the significance of the research (section 1.10). Finally section 1.11 provides a précis of the remaining chapters in the thesis.

1.2 SETTING THE CONTEXT

From a young age I had the desire to be a nurse and subsequent study enabled me to achieve this goal. I have been privileged to work in many settings, some autonomous in practice, many within great teams and with the client and consumers at their core. There have been others where leadership was lacking or was limited in its scope. As a bedside nurse caring for patients and residents I could see the effects of leadership on patient care. Later undertaking the role of Director of Nursing saw the complex world of economics, care, staff and resourcing become a reality. I knew that to understand what leadership was at the frontline of care was important as it was a question not frequently asked, but rather assumed from an organisational context. Leadership, I believed was far greater than this organisational approach. There appeared to be so many facets, so many variations and the complexities from an individual, team or organisational perspective further elaborated this. I identified that it was the leadership that comes from individuals, such as the RN, who works in a team within an organisation such as a residential aged care setting that required greater understanding. It was about the leadership, not the management.

1.3 INTRODUCING THE RESEARCH

It is the intent of this research to learn from the experiences of RNs, endorsed enrolled nurses (EEN) and UHCWs about the leadership role the RN assumes in the residential aged care setting. The research is greater than a leadership style, or the experience of one RN, and more than identifying what attributes are present in staff leading teams. It is about hearing and learning about the ‘what is’ of RN leadership from the experiences of staff. It concerns the narrative and the anecdotes that evolve from the voices of clinical care staff and what meanings are derived from these to

gain a greater understanding of the phenomena of RN leadership within residential aged care settings in Australia.

To provide clarity, management is a different concept and construct to leadership. Management refers to the coordination of resources and how these are utilised to achieve organisational goals (Deutschenforf, 2010). Management is about the requirements of a logistically planned organisation that occurs in a clinical setting of all human, financial, fiscal, capital and technological resources (Deutschenforf, 2010; Wilkinson, Nutley, & Davies, 2011). In contrast, leadership is both an individual and a team concept, aligned with influencing the people in and within an organisation through guidance, motivation and mentorship to achieve the required goals (Bass, 1999; Berson & Halevy, 2014; Deutschenforf, 2010; Senge, 1993).

The prevalence of an aging society is dependent upon the Australian health system (AIHW, 2013; Bellis, 2010; King, Mavromaras, & Wei, 2013). As the demand for services increase and consumer awareness is heightened, the expectations placed on staff working in the system increases proportionally. What is acknowledged is that the sector has a predominance of care attributed to the social care model, and uses a high number of UHCWs to fulfil resident cares on a day to day basis. The evidence from the Australian Bureau of Statistics (ABS), (ABS 2014, p. 24), identifies that '68.2% of the residential aged care workforce is derived from within the UHCW category'. A mere '14.9% of the workforce have employment as RNs and 11.5% equating to the role of the EEN' (ABS, 2014, p. 24). Exponentially higher is the numbers of UHCWs, however the position descriptions have the role of the RN responsible and accountable for the supervision and oversight of the care provided by these staff members.

The questions to ask are numerous. What is the leadership role of the RN in the residential aged care setting? What is the experience of this leadership as seen by clinical care staff? Importantly, the question of what is the RN leadership experience perceived by staff living in the moment of working shift by shift with RNs? There is much written about the experience and impact of leadership and management in the corporate sector on staff experience (Allen & Dennis, 2010; Avolio, Walumbwa, & Weber, 2009; Drescher, Korsgaard, Welpe, Picot, & Wigand, 2014; Kanter, 1981; Klein, Ziegert, Knight, & Xiao, 2006). There appears to be limited information with

particular reference to the experience of RN leadership as experienced by the clinical care staff in residential aged care settings in Australia. The responses to these questions are contained in the pages of this thesis. This chapter introduces the overall research and begins by outlining the aim and the background to the research. The research question is presented, followed by the research methodology and method. The phenomenon of interest is introduced and the potential significance of this research is discussed. A synopsis of the research setting is provided.

1.4 THE RESEARCH QUESTION

The overarching research question is:

What is the clinical care staff experience of the leadership role of the RN in residential aged care settings in Australia?

1.5 THE RESEARCH AIM

The accounts collected from clinical care staff were highlighted and explored in more depth through an interpretative hermeneutic phenomenological analysis of the leadership role of the RN. The research design considered the leadership experiences, challenges, barriers, requirements in care provision and the interactions of the RN with the clinical care staff and broader health care team.

The aim of the research was to:

1. Identify the different levels of clinical care staff experience of leadership from the role of the RNs in the residential aged care setting in Australia.

2. Explore the experiences of clinical care staff in understanding the leadership contributions and challenges to the role of the RN in the residential aged care setting in Australia.

1.6 RESEARCH DESIGN AND METHODOLOGY

To determine a suitable research methodology is important in the process of identifying and describing experiences. These experiences are not always expressed in objective quantitative data collection methods alone. Meaning and understanding from a humanistic perspective is often sought through a qualitative lens where the interpretation of meaning and understanding can be found (Liamputtong, 2013; Sandelowski, 2015). Qualitative research is concerned with 'measuring attributes and relationships in a population' (Mannix, Wilkes, & Daly, 2013, p. 353). It was this that guided the selection of the methodology.

Phenomenology as a methodology met the premise of this research as it enabled the experience of leadership as expressed by the clinical care staff to come alive. In this context phenomenology seeks to answer questions of meaning in understanding the lived experiences of staff experiencing RN leadership in practice from within selected residential aged care settings. It was through the use of an interpretative phenomenological research approach surrounding the 'what is' question of the RNs role in aged care leadership that the description and interpretation of the experience was revealed. It was the disclosure or the interpretation of the meaning of RN leadership that was important. To this end, it was about achieving a sense of understanding. The clinical care staff experiences of RN leadership within this context are culturally bound by the norms and expectations of their professional group, and by the ethos of the aged care facility. It was anticipated that this experience would be identified by gathering text from those living it, and then by the interpretation of this text into meaning (Dowling & Cooney, 2012; Mapp, 2008; Salmon, 2012).

The research design followed the approach of seeking information through the use of semi-structured in-depth interviews (Smith, Flowers, & Larkin, 2013; Streubert & Carpenter, 2011). The experiences obtained were then explored for their descriptive understanding. The reflection and analysis of this descriptive context provided a more meaningful reflective process of cycling in and through the narratives until deeper meanings appeared or were identified (Gadamer, 2013; Moules, McCaffrey, Field, & Laing, 2015; Pringle, Drummond, McLafferty, & Hendry, 2011). Once identified the exploration of these meanings was contrasted

with the literature. The considerations or recommendations for practice within the residential aged care setting were then outlined. Importantly, this is the area where the essence was brought to reality in a more practical, applicable context.

A team led, directed and accountable to the RN saw the harmony or synthesis of the whole brought together as a collective combination that formed the 'home' for the aging person in residential aged care. This relationship between staff, the consumer and organisation links the complexities of care provision, decision making, coordination and clinical reasoning that forms the role of a RN in this setting (Duffield et al., 2014; Grealish, Bail, & Ranse, 2010; Havig, Skogstad, Veenstra & Romøren, 2011).

The research engaged the use of a metaphor to describe the topic surrounding the leadership role of the registered nurse in a team of staff in the residential aged care setting. The use of the linguistic metaphor allowed for the description of the topic in terms of a semantically unrelated domain that is familiar to many. The metaphor was visualised through the instruments and music of an orchestra. Most people are familiar with the name and music of Beethoven. Beethoven spoke of the richness of an artist's material and the extent and depth of the organisation of this material to reveal a quality in the music played (Sullivan, 1960). Metaphorically the orchestration of this richness and depth of the music is represented in the leadership, the coordination and the care provided and evaluated by RNs employed in residential aged care settings. It is not unlike the analogy described by Wheatley (1993, p. 44) where the crucial role by leaders is about *'... selecting the melody, setting the tempo, establishing the key, and inviting the players'*. To understand and appreciate the complexity of leadership, the extent and depth of the clinical care staff involved in resident care, their voices must be visible, heard and understood. The metaphor evolved throughout the research as the orchestra is assembled and the music develops. It has been used in the writing of this thesis to add a level of understanding with a metaphor that readers are able to understand and relate to.

1.7 THE PHENOMENA OF INTEREST

The focus on aged care nursing is more critical in Australia than ever before as the aging population and a substantive increase in aged care requirements prevail. The onus on understanding care requirements of aging Australians, staffing capacity and what works within the aged care setting is important. These areas set priorities and target areas to improve systems, provide efficiencies and the best possible care for residents into the future (Angus & Nay, 2003; Baines, Charlesworth, Turner, & O'Neill, 2014, Bishop, 2013).

The clinical care team in the aged care setting consists of the RN, the EEN and the UHCW. The clinical care team provides the daily clinical care requirements and resultant clinical decisions for residents. The workforce structure creates the need for strong clinical leadership from the RN role to ensure the creation of work teams that provide quality resident outcomes (Chen & Silverthorne, 2005; Stanley, 2014). The theoretical construct discussed by Kanter (1977) outlines the importance of structure, power, and workplace relations in an organisation. In determining the essence of RN leadership in residential aged care, the research question asked about the experiences as understood and lived by staff that worked with and as RNs in the setting. It is concerned with their experiences, and the meanings they saw as they worked each shift in this team, and in this environment.

These experiences relate to the theoretical construct of Kanter (1997) as greater exploration of the leadership role and the voice of staff in establishing the leadership role was sought. It was the relationship connecting the RN, EEN, and the UHCW caring for the older person in residential aged care settings that generated questions. This was identified early in the scoping stages of the research where approaches were made from a large aged care organisation to assist in understanding this leadership role. The discussions with residential aged care facility managers outlined it was the role of the RN to coordinate care for large numbers of residents. It was the role of the RN to supervise and coordinate care practice in the setting with support and care provision being provided by the, EENs, and UHCWs. The many roles of supervision and practice formed an overarching multilayered role for the RN. The leadership role was not clearly defined and became the focus of the research.

In researching the area of leadership there is a myriad of literature on leadership styles, attributes and characteristics of leaders (Atsalos & Greenwood, 2001; Atsalos, O' Brien, & Jackson, 2007; Bass, 1985; Cummings et al., 2010). Leadership plays a critical role in setting the climate for practice development and the outcomes of care (Cummings et al., 2010; Jeon, Merlyn, & Chenoweth, 2010; Yun-Hee, Simpson, Chenoweth, Cunich, & Kendig, 2013). This is particularly relevant within the complex and continually changing world of health and aged care (Cook & Leathard 2004; Macphee & Suryaprakash 2012). To maintain standards, clinical expertise and communications in such a setting requires effective change and an innovative set of interactions and relationships as well as the leadership necessary to create them (Lewis, 2012; Macphee & Suryaprakash, 2012). The effect of leadership will determine an organisations ability to change and learn, resulting in an organisations willingness to promote or inhibit change (Lewis, 2012; Yun-Hee et al., 2013). This notion creates challenges for RNs in the aged care setting as a balance between leadership roles and resolving immediate and conflicting clinical pressures is required. This is coupled with the need to make progress in staff development activities and the identification and implementation of evidence-based practice and quality improvement in the setting.

The concept of 'what is' leadership is not new, but the exploration of this concept within the residential aged care setting in Australia has not been captured from the experiences of clinical care staff. What is known from the literature is that leadership is a process of influencing people to achieve goals within an organisation (Bass, 1985; Deutschenforf, 2010; Howieson & Thiagarajah, 2011; Summerfield, 2014). Leadership is a concept, an action which is related to influence, communication and motivation to achieve goals in and within teams of people (Bass, 1985; Howieson & Thiagarajah, 2011). The descriptions of leadership are varied and many, and pertain to the process of influencing behaviour and interactions between individuals (Deutschenforf, 2010; Stanley, 2006; Summerfield, 2014; Walker, Cooke, Henderson, & Creedy, 2011). It is the focus on these areas surrounding the role of the RN in the residential aged care setting that required greater understanding.

1.8 THE RESEARCH SETTING

The research setting was a group of residential aged care facilities located in Southern Queensland and South Australia. The settings provided care to residents within high care, low care, hostel and respite services (including palliative and dementia care) to predominantly older persons. The facilities were and still are governed by large aged care providers in Australia that operate both residential and community based health services. All facilities are operated locally by a Facility Manager with a more centralised hierarchy and Board of governance for more strategic planning and group decision making. This multisite project had organisational ethical approval and research endorsement from both the larger strategic level of the organisations and also through Facility Manager acceptance and engagement at a local facility level.

1.9 RESEARCH JUSTIFICATION

For many years I have worked in teams and have experienced many different shifts where I have left at the end of the day feeling content even when the day has not gone to plan. That is what nursing is about; often things do not go as planned. As nurses, the day is consumed with the human nature of caring at a time when all is not well with an individual (Pearson, Schultz, & Conroy-Hiller, 2006; Venturato & Drew, 2010; Yun-Hee et al., 2013). For these reasons, each individual experiences their own vulnerability, fragility and anxiety. For the RN it is the delicate balance between the art and the science of knowing when to intervene, assess, and implement cares and when to support and empathise. It is also about knowing when to 'just be there' in the caring sense of 'nursing' (Williams, McDowell & Kautz, 2011). It is in these circumstances that the leadership and the support of colleagues count. It is this component that is of particular importance when working with residents who have health and aging complexities but reside within a facility focused on social care and health provision. How this balance is met, how the art and science of nursing occurs and is seen, heard and felt is through the leadership encapsulated in the guiding role provided by the RN (Williams et al., 2011).

It was the reality of my situatedness within the social, cultural and historical world of nursing, leadership, and aged care that formed the reasons for this research.

Whilst a number of systematic reviews have focused on determining leadership styles, leadership characteristics, and outcomes within the residential aged care setting, these reviews appear to have summarised the outcomes generally in relation to leadership, rather than having a specific focus on the RN working in the residential care environment (Chenoweth, Jeon, Merlyn, & Brodaty, 2010; Dwyer, 2011; Mannix, et al., 2013; Pearson et al., 2007). It was anticipated that the contributions from RNs, EENs and UHCWs of the leadership role would identify and describe the phenomena of RN leadership in residential aged care.

Unequivocal evidence stemming from the literature submits that effective nursing leadership is vital in the provision of guidance when solving complex problems related to nursing care delivery (Bellis, 2010; Cummings et al., 2010; Doody & Doody, 2012). With a documented shortage of nurses and particularly experienced nursing leaders in Australia, it is becoming increasingly important for residential aged care organisations to develop or grow their own nursing leaders to ensure a positive outcome for the residential aged care sector (Jackson, Hutchinson, Peters, Luck, & Saltman, 2013; Spence-Laschinger, Wong, & Grau, 2013). Leadership attributes or qualities that focus on people and relationships are vital, as these empower RNs to lead in clinical settings and successfully achieve organisational and effective resident outcomes (Atsalos & Greenwood, 2001; Atsalos et al., 2007; Cummings et al., 2010). Increased understanding of the leadership role of the RN assists in understanding future mentor and education parameters within residential aged care nursing. Importantly in residential aged care organisations, this research may assist in the identification or clarification of residential aged care nursing leadership structures that enhance nursing staff support, and retention and education for the RN. This research could offer a pathway of determining the leadership contribution and role of the RN in residential aged care by examining the concept through the voices of clinical care staff working with RNs in these settings.

1.10 RESEARCH SIGNIFICANCE

The significance of the research is in its implications for RNs and their daily practice of caring and leading within the aged care sector. Clear articulation of the standards of the RN and the inherent requirements to demonstrate nursing leadership within the residential aged care environment is evident. A direct approach from one

of the settings for research in this domain provided impetus for the study. The need for the organisation to understand and capture the leadership role of the RN was sought. This generated further discussion and resulted in the inclusion of the second organisation also seeking to find answers to the same question.

The literature affirms that leaders in residential aged care settings have traditionally used authoritarian approaches, using top down communication and decision making of the largely semiskilled and unskilled workers (Josefsson & Hansson, 2011; Saccomano & Pinto-Zipp, 2011; Tyler & Parker, 2011; Walmsley & McCormack, 2015). Research findings suggest that authoritarian approaches are problematic, noting that nursing staff feel powerless, with greater staff turnover, less communication and less teamwork experienced (Havig et al., 2011; Josefsson & Hansson, 2011; Tuckett, Hegney, Parker, Eley, & Dickie, 2011; Whyte, 2007). In contrast, relationship-oriented leadership styles have been noted to create teamwork, increase communication both vertically and horizontally among staff, and decrease staff turnover (Chu, Wodchis, & McGilton, 2014; Spruill & Heaton, 2014). McKee, Charles, Dixon-Woods, Willars, and Martin (2013), establish the need for a more dispersed approach to leadership than just those of a formal position but secondary from that of the clinical domain. It is the diverse nature and balance of both the informal and formal leaders that provide the catalyst for a distributed leadership approach within the health care setting.

The linking with what was known in the literature with a further exploration of the leadership role of the RN in residential aged care was warranted to gain a more thorough understanding of organisational processes and the identification of the nature of this leadership. Further reflective thought and practical application of the considerations for practice was required. Particularly the concepts of education and the development required by RNs entering into a career in aged care nursing could be reviewed. From an organisational context, this research offers the ability to know and understand team dynamics and the role the RN portrays in both a formal and informal clinical leadership position of leading teams in the day to day aspects of caring for the older person.

Understanding the complexities of the nursing workforce combined with an unregulated workforce in residential aged care settings provides caution and complexity. Within the scope of practice requirements and also the supervisory role that the RN holds is the accountability for the care provided, and the guidance and supervision of staff on their watch. There is a need for research that seeks to clarify the role the RN has in supporting and guiding care practices and staff supervision in residential aged care. Dwyer (2011, p. 390), articulates that 'further research is needed in leadership styles, learning and development for nurses in general, but particularly in the aged care sector'. It is this 'what is' of leadership that required articulation and interpretation.

1.11 THESIS OUTLINE

The thesis is structured into ten chapters. Chapter 1 presents an overview of the context of leadership in the residential aged care setting. This is followed by a discussion on the definition of leadership practice in nursing, and the background to the research question and aim are presented. The justification and significance of the research are discussed and the research design, methodology and setting are introduced.

Chapter 2 provides a theoretical overview of the literature surrounding the context of aged care nursing, the legislative and historical underpinnings to the aged care setting in Australia and the notion of an aging population and the negative connotations derived from the notion of being old. The overarching discussion on leadership and the definitions and practice context with particular relevance to nursing and healthcare settings is presented. The findings from the literature are discussed and also linked to the roles of clinical care staff working in the residential aged care setting in Australia and the models of care that follow. Chapters 2 and 3 continue discussions surrounding the challenges identified, and the teamwork and power structures that are evident within organisations. Chapter 3 specifically discusses these aspects with respect to the works of Rosabeth Kanter (1977). This discussion provides a framework to understand the nuances of an organisation, its structure, content and workings and the relationships between staff and the RN.

Chapter 4 describes and justifies the methodology utilised in this research. Linking directly with the methodology, Chapter 5 provides an introduction to the research design and methods. Inclusive in this chapter is an introduction to the participant groups, the research setting, data collection strategies, ethical considerations and data analysis processes. Chapter 6 introduces each of the participants engaged in the research.

Chapters 7, 8 and 9 present the findings of the research in both descriptive and interpretative forms. Chapter 7 outlines the descriptive findings with the inclusion of anecdotes from staff specifically outlining aspects of the RN leadership role.

Chapter 8 and Chapter 9 present the interpretative analysis of the identified categories of understanding and application respectively. The chapters articulate the interconnectedness of the categories of understanding and application and the derived meanings of the leadership role of the RN collectively. The linkage of the research to the literature and best practice standards is shared.

Chapter 10 presents the outcome of the definition of the leadership in the context of the RN in the residential aged care setting. Conclusions are discussed that have been drawn in relation to the theoretical context of the literature and the results of the contributions found in the research. Considerations for practice are presented. Limitations of the research are noted and opportunities for future research are suggested.

1.12 SUMMARY OF CHAPTER 1

This chapter has discussed the background to, and justification for the study. The research aims and the research question have been outlined along with a description of the setting and the significance of the research linking these back to the research question. An understanding of the research question is further examined through the lens of the literature in Chapter 2. The literature provides an overview of the leadership role and the context of the setting of residential aged care in Australia.

Chapter 2: Literature Review

2.1 INTRODUCTION

Understanding the complexities of the care and leadership provided by RNs requires a connection or 'bridge' between the literature and the reality of the clinical context. As Wheatley (1993, p. 44) noted '…music comes from something we cannot direct, from a unified whole created among the players.' Like music, leadership presents in many different forms and contexts and as such requires clarification through an understanding of the literature, the definitions and the relationship between the two. To understand the leadership role of the RN an exploration of the literature is required that has a focus on leadership and aged care in Australia. Specifically the concept of leadership (sections 2.2), leadership theory and health and clinical leadership definitions (sections 2.3; 2.4; 2.5), the historical underpinnings and background of aged care (sections 2.6; 2.7; 2.8; 2.9), the roles and responsibilities of the team and the staffing models in the setting (sections 2.10; 2.11). The literature remains incomplete without the inclusion of discussions surrounding the RN. These areas include the communication strategies in nursing, staff education in practice and RN education strategies and options (section 2.12), career pathways (section 2.13) and nursing governance in Australia and the implications for the RN (section 2.14). Section 2.15 outlines the challenges in the workforce and the implications of these on the leadership role. Section 2.16 highlights the implications from the literature and develops the organisational context that the RN works in that is further discussed in Chapter 3.

Leadership in residential aged care nursing is framed in many respects by historical underpinnings, an aging population, regulatory guidance, tradition and fiscal resourcing (Baines et al., 2014; Bishop, 2013; Sonaware, 2015; Walmsley & McCormack, 2015). Historically, the aged care setting has been dominated by a medical model of care; highly regulated and yet heavily under resourced (Walmsley & McCormack, 2015; Weller, Boyd, & Cumin, 2014). Integral in contemporary aged care facilitation and found in the literature is the shift to more resident centred approaches in care delivery (Baines et al., 2014; Bishop, 2013; Caspar & O'Rourke,

2008). These approaches present challenges to the role of the RN working in the sector and demonstrate a shift in care approaches and funding mechanisms. These challenges are combined with the changing complexity of care and the knowledge that people are living longer and wanting aged care services that meet their perceptions of what is appropriate, affordable, and acceptable to them. The perception of aging and how the terminology of caring for the older person, aged care or nursing home care is portrayed in the literature requires examination and discussion. This allows for the overall perception of 'aged care' to be more readily understood. It is this perception that often leads to feelings of negativity about the role of the registered nurse, a leadership role responsible and accountable within the setting (Tuckett, Parker, Eley, & Hegney, 2009; Tuckett et al., 2011). An exploration of the literature enables the reader to understand further the context of the role of the RN in aged care.

The narrative literature review encompasses a volume of reading from within the subject of nursing, health, nursing and leadership, aged, and aged care in their generic and then more refined terms. Given the lack of aged care leadership specific literature in some of these areas, the literature review is also inclusive of responses with a focus on leadership from a broader sense within health, education and business literature sources. This is further reinforced from the broader health, education and business world on leadership and management processes and challenges. The literature search used the included search terms of 'old' 'aging' 'aged or health policy' 'nursing home and care (nursing)' RN + aged care, personal care worker/UHCW/care aid/ care worker +/- aged care, EEN/div 2 nurse +/- aged care. A more refined search in leadership from historical underpinnings to current practice proved worthy in the scope of leadership and aged care, leadership and health/nursing/business/education, leadership practice, style and attributes/aged care/health/nursing/business/education, leading teams, teams, teams in nursing, clinical leadership and shared governance and nursing/health/business/education. More generically, aged care has been searched extensively from government based reports, historical reflections of aged care policy development in Australia; the Australian health care system, systematic reviews and narrative syntheses. The aging population in Australia/developed countries/internationally; social care models and medicalisation of care within the aged care context has also been searched. The

literature would not be complete without a search strategy on nursing and the complexities of scope of practice and the challenges to care provision. These include retention and recruitment, motivation, empowerment, power, influence, reward, recognition and job satisfaction, staffing models, models of care, care provision, career pathways, staff productivity, care quality, compassion, palliative care, dementia care, and resident outcomes/benefits/quality of care and their derivatives that outline an impact or association with the leadership context in aged care nursing.

The key terms in this narrative review have been searched through a number of databases and search engines inclusive of CINAHL, Medline, Cochrane Library, Joanna Briggs Institute, SAGE, Academic Search Complete, AIHW Data online, AusStats, RCN Collection, Business Source Complete, ERIC, SAGE Management and Organisation Studies, Wiley, SAGE Research Methods online, Google Scholar/plus, EBSCOhost and PubMed. The literature review revealed an array of information surrounding the context and practice of nursing in the residential aged care setting. This was refined further to identify key resources specifically relating to the role of the RN leadership in residential aged care settings. The scope of the literature provided a clear sense of the intricacies and complex nature of the direction of the leadership role of the RN in this setting.

2.2 THE DEFINITION OF LEADERSHIP

The complexity involved in understanding what leadership is, particularly in aged care, creates a discourse of many thoughts and perspectives. Research in the area of nursing leadership is expansive however the particular nuances required are described by the attributes that present or the style of leadership articulated in the circumstances of discussion (Martin & Waring, 2013; Pearson, Schultz et al., 2006; Spence-Laschinger et al., 2013; Stanley, 2006; 2014; Stout & Weeg, 2014). The web of interactions, contacts, connections and communications that need to intricately yet explicitly link to ensure that the staff, the resident, families, visiting community and medical and allied health staff are all focused and satisfied with the outcomes of care delivered are vast (Howieson & Thiagarajah, 2011; Jeon, 2014; Jeon, Glasgow, Merlyn, & Sansoni, 2010; Jeon, Merlyn et al., 2010; Stanley, 2014). The notion of one definition of leadership would not be useful as like aged care it contains many concepts and complexities (Anonson et al., 2014; Atsalos & Greenwood, 2001;

Brownie & Horstmanshof, 2012; Lichtenstein & Plowman, 2009). Defining leadership in a complex and multi-dimensional environment requires much consideration. What is known from the literature is that the attributes of a good leader include the provision of clear expectations, setting standards for work performance, encouraging, initiating, and providing a supportive environment (Bishop, 2013; Cummings et al., 2010; Forbes-Thompson, Gajewski, Scott-Cawiezell & Dunton, 2006; Stanley, 2014).

A quantitative study by Forbes-Thompson et al. (2006) exploring the interplay between residential aged care organisational processes and the characteristics of leaders across 101 nursing homes engaging 3894 staff, identified that staff members had different perceptions of communication, teamwork and leadership. The study conducted by Forbes-Thompson et al. (2006, p. 950), further outlined that '52 percent of staff believed that nursing leaders made decisions without input from other staff.' This study indicated the need for additional research into understanding how staff members perceive leadership within their workplace, in this instance the residential aged care setting (Forbes-Thompson et al., 2006).

Historically, the definition of leadership continues to evolve with leadership defined as behaviours a leader exhibits as they manage interactions, tasks, and situations associated with a designated work area (Taunton, Krampitz, & Woods, 1989). This broad historical definition outlines further the influence a leader exerts and the power they have within a work environment. It is these attributes that may have a positive or negative influence on an employee's decision to work in a particular environment (Acree, 2006; Rokstad, Vatne, Engedal & Selbaek, 2015; Spence-Laschinger et al., 2013; Taunton et al., 1989). Applying this definition indicates that the organisational priority for leaders is measured by the effectiveness of interactions and associations within the given setting.

Nurse leaders are the internal stakeholders who are able to inspire their team, connect with their staff, seek their input and have high levels of emotional intelligence in an organisation (Anonson et al., 2014; Hurley & Hutchinson, 2013). This is an interesting definition in that it identifies with a sense of shared responsibility led from a person that connects the team. The definition also outlines that it shares the responsibility yet provides the direction and support necessary. It

creates a picture of leadership in a team, not as a stand-alone act but a function of a whole team. It lends substance to the notion that we can all be leaders and concurs with the definition outlined historically by Lewin, Lippitt, and White (1939, p.21) where leadership was viewed as a style linked explicitly to 'how you relate to employees'.

Understanding the 'what is' notion of the leadership role of the RN from the clinical care staff in an aged care setting requires a more definitive starting point. As a result to understand the 'what is' of leadership, the notion of leadership will be defined on the basis of an individual's actions, rather than any formal hierarchical position a RN may hold. To this end, all RNs are presumed to hold a leadership role, and it is in this role that clinical care is coordinated and that communication with and amongst teams occurs (Castle & Decker, 2011; Cummings et al., 2010; Duffield, Roche, Blay, & Stasa, 2011; NMBA, 2016b; Stanley, 2014). It is where decisions are guided and staff supported, where communication is key and where learning happens (Arnold & Boggs, 2013; Chen, Sharma, Edinger, Shapiro, & Farh, 2011; Spence-Laschinger et al., 2013). The presumptions of what this leadership role of the RN entails is an area of discussion in the literature that the research aims to search for greater understanding and the greater depth of knowledge of the leadership role in the residential aged care setting.

Wong and Cummings (2007), describe leadership as a process to achieve goals. More specifically Shortell and Kaluzny (2000, p. 34), define leadership as the 'process through which an individual attempts to intentionally influence another individual or a group to accomplish a goal'. Similarly, leadership has been described as the 'behaviour of an individual when directing the activities of a group toward a shared goal' (Al-Sawai, 2013, p. 285). The similarities of the notion of shared outcomes appears within many of the definitions, and concurs that leadership is perhaps greater than an individual alone and more broadly the goal of leadership is a shared vision achieved through and within teams (Al-Sawai, 2013; Bamford-Wade & Moss, 2010; Marles, Moloney & Taylor, 2015). This places the onus on more than one individual and asserts the importance on team dynamics, communication, mentoring, encouragement and personal interaction as needed attributes in a leader (Buckner et al., 2014; Schaik, O'Brien, Almeida, & Adler, 2014; Stanley, 2014).

Damschroder et al. (2009) wrote of four types of leaders all of whom have the responsibility of engaging staff, mentoring and influencing attitudes and beliefs. Firstly Damschroder et al., (2009) discuss opinion leaders, as these leaders have formal or informal influence on the attitudes and beliefs of their colleagues. The next two types of leaders that arise are within the categories of formally appointed leaders that appear in settings as care coordinators, shift coordinator or team leader roles, and champions who support, guide and mentor others and work with staff on change and change management obstacles in the workplace. The final category of leader is seen as the external agents of change with the formal role of working with the team toward a common organisational goal.

de Waal and Sivro (2012) explored through quantitative means, the notion of servant leadership and the relationship with organisational performance. The research background identified the ideal leader as having the ability to exert power and influence to motivate followers in achieving organisational goals. Venturato and Drew (2010) explored the use of an innovative model of care in an Australian setting with the rationale highlighting the complex, nature of staffing issues in the sector. The model embraced a number of components from human, organisational, personal and interpersonal areas that also considered education, clinical leadership and delegation and accountability (Venturato & Drew, 2010). The results indicated that models in residential aged care settings needed to consider the leadership provided by the RN, with a focus on leading in practice rather than the conventional doing in practice (Venturato & Drew, 2010).

The complex nature of leadership and the many and varied definitions in its description have led many theorists to capture the essence of leadership through the characteristics that present in a leader. Historically, leadership has been defined by various constructs and an array of characteristics grouped together to create a particular style or leadership theory (Isaacson & Ford, 1998; Reeves & Macmillan, 2010; van Dierendonck, 2010). A shift is apparent in leadership research as the focus of leadership has changed from the leader to a broader context that now is inclusive of followers, peers, supervisors, the work environment and organisational culture (Avolio et al., 2009; Kean & Haycock-Stuart, 2011; Kean, Haycock-Stuart, Baggaley, & Carson, 2011). Leadership theories now acknowledge the complex process that it actually is, and debate continues on what is the ‘best’ style or theory in

an organisation (Hurley & Hutchinson, 2013; Pearson et al., 2007; Pearson, Schultz, et al., 2006; van Dierendonck, 2010).

2.3 LEADERSHIP THEORIES DESCRIBED

Traditionally there have been a number of different leadership theories, many of these focused on the quantitative study of traits, behaviours and attributes than searching for the experience within it (Gambrell, Matkin, & Burbach, 2011; Kouzes & Posner, 2007). Each style shares its own set of unique attributes and characteristics. However rather than the assessment of a particular style of leadership, there is a need to further understand the perceptions of staff in this leadership. Leadership plays a critical role in the day to day work of an RN as it is the key influence and lead in decision making, and secondly, in ensuring quality resident outcomes (Anonson et al., 2014; Cummings et al., 2010; Yun-Hee et al., 2013).

It is known that it is the RN that leads the team in the residential aged care service domain (HWA, 2012; Jeon, 2014; Lynch, McCormack, & McCance, 2011). What is known is that poor leadership is fundamental to many aged care sector concerns and poor resident outcomes that include pressure areas, dehydration and falls (Baer, 2006; Hurley & Hutchinson, 2013; Jeon, Merlyn, et al., 2010; Wong, Cummings, Ducharme, 2013). There are a variety of styles of leadership identified in the literature from autocratic, democratic, directive, transactional, transformational, participative, task oriented, relationship oriented, servant and distributive to name just some (Acree, 2006; Allen & Dennis, 2010; Avolio & Bass, 1999; Bass, 1985). An understanding of leadership styles generically can help those working in the industry to further understand the complexities involved or simply the way in which some leaders operate.

In the aged care setting traditional leadership theories have existed with commonalities that relate to servant, relationship and task oriented leadership approaches (Cummings et al., 2010; Dwyer, 2011; Garber, Madigan, Click & Fitzpatrick, 2009; Hodgkinson, Haesler, Nay, O’Donnell, & McAuliffe, 2011; Hurley & Hutchinson, 2013; Jeon, Merlyn et al., 2010; Venturato, 2007). Current research identifies with a more distributed model of leadership in the setting with a

greater emphasis on clinical leading from the RN (Bolden, 2011; Bush, 2013; HWA, 2012; Marles et al., 2015; Stanley, 2014). In seeking to know more about this leadership, strategies and improvements are able to be discussed and generated. The concept of linkages and understanding of relevant leadership theories articulates further the characteristics and ideals of leaders in the workplace.

2.4 LEADERSHIP FOR HEALTH SYSTEM SUSTAINABILITY

The *Health Workforce Australia Report (2012, p.7) into Leadership for the Sustainability of the Health System*, identified that the required leadership in the health sector needed to 'shift in ways of thinking about health system and workforce design and planning'. The report further articulates that the system needs to look seriously at ways to increase leadership capacity from within the system itself (HWA, 2012). The Report (2012) captures the historical underpinnings of Lewin et al. (1939) and builds the notions of leadership that encompasses the definitions previously discussed. It concurs with the literature and adds to the notion of complexity in understanding the phenomenon of aged care nursing.

Within Australia, this Report (2012) and further work collated through consultation with health industry professionals has enabled a greater collaborative model to be established that provides a national framework for health leadership (HWA, 2013). The framework titled *"Health LEADS Australia"* has been promoted at national aged care symposiums and workshops to assist in providing a structure for health organisations to work toward a more distributed model of leadership that focuses on the people in the system (HWA, 2013). There are five areas of focus in the model: leading self, engaging others, achieving outcomes, driving innovations and shaping systems (HWA, 2013). The areas lend themselves to a significant shift in the way leaders conduct business in many health care areas and will not come without challenges and the need for greater understanding, training and mentorship in this space.

2.4.1 Leadership by 'Doing'

In the health industry, nurses learn to manage and lead often, by 'doing', that is, by being allocated to the role of team leader or by showing an interest in leading the team (Venturato & Drew, 2010). In the residential aged care setting, RNs lead

the team usually as the sole RN rostered on shift with the responsibility and accountability for the care of all residents. This 'learning on the go' often equates to problems in translation to practice and has a sense of cultural doing rather than practice through authority and discernment (Manojlovich, Barnsteiner, Bolton, Disch, & Saint 2008; Swearingen, 2004; Wong & Cummings, 2007). The historical underpinnings of the aged care work environment encourage the staff in the setting and its leaders to make decisions and coordinate care priorities based on what needs to be done (Ascencio, Carter, Dechurch, Zaccaro, & Fiore, 2012; Havig et al., 2011). This type of leadership is based on the premise of a functional existence with the role of leader 'to do, or to get done what is needed' as it is this that creates a sense of the 'functional problem solver' (Asencio et al., 2012, p. 491). This functional based philosophy can be led in a number of ways. The first in the autocratic ideals of one leader and delegation of work from within one main person, to one with tiers of delegation from a number of leaders with varying levels of delegation or authority (Asencio et al., 2012; Bergman, Rentsch, Small, Davenport, & Bergman, 2012; Chreim, Williams, Janz & Dastmalchian, 2010; Dearmon, Riley, Mestas, & Buckner, 2015; Wang, Waldman, & Zhang, 2014).

2.4.2 RN Leadership and Decision Making Practice

There are times in nursing where decision making requires a definitive approach; it is at these times that autocratic or transactional leadership works best. Transactional leadership encompasses the consideration in relation to the experience and capabilities of the individual (Aviolio & Bass, 1999; Doody & Doody, 2012; Hamstra, Van Yperen, Wisse & Sassenberg, 2014). In residential aged care settings this is seen as an approach where the percentage of workforce is high in unskilled workers, resulting in a leader who is required to make decisions or intervene particularly if resident safety is at risk (Duffield et al., 2014; Hayes et al., 2012). There will always be instances in health care where the RN is required to make decisions based on critical thought, patient assessment and the potential for negative outcomes if a particular intervention does not occur. However, it is in this style of leadership that decision making practice is unilateral, which in turn can negatively affect the team and the interplay of dynamics within. The exploration of the leadership role of the RN will add further to this discussion through the anecdote gained into the 'what is' of the leadership role. The presumption that this style of

leadership would work well in the residential aged care setting could prevail as the existence of a majority workforce of UHCWs is seen. However, the differential power bases that exist between positions and roles in the setting contradict the rationale for this style of leadership. The demand from staff includes one of seeking inclusion and engagement in the work conducted.

2.4.3 RN Leadership and Followership

Transformational leadership was first considered by Bass (1985) from within the organisational context. It is in this leadership theory that attention to the development of followers through individualised consideration, intellectual stimulation, and supportive behaviour appear as characteristics (Bass, 1985). The aim in this context focussed on what is good for the organisation (Bamford-Wade & Moss, 2010; Cummings et al., 2010; Doody & Doody, 2012; van Dierendonck, 2010). Equally, servant leadership carries with its broad definition similarities characterised with like attributes with a focus on humility, authenticity, and interpersonal acceptance (Barbuto, Gottfredson, & Searle, 2014; de Waal & Sivro, 2012; Goldstein, 2010; van Dierendonck, 2010).

Servant leadership has similarities to transformational leadership, however it is distinguishable by the knowledge that this style of leadership has a focus on followers. There is a strong sense of answerability from leaders to themselves and to others. There is also a product of accountability where responsibility is assumed for the choices made (Barbuto et al., 2014; de Waal & Sivro, 2012). Servant leadership has its historical underpinnings in the primary desire 'to serve and do well for others' and is seen in the residential aged care setting (Barbuto et al., 2014, p. 315). Transformational leadership focuses on 'developing an organisation's capacity to innovate' (Hallinger, 2003, p. 330), rather than a focus on people to do well. In some respects it can be viewed as a form of distributed leadership in that it also shares an interest in developing a shared vision and goal (Hallinger, 2003).

2.4.4 RN Leadership and 'Being in Charge'

In an autocratic style of leadership the leader may seek input from others, however will ultimately make their own decision (Castle & Decker, 2011; Murphy, 2005). Historically, the notion of a leader was one that was 'in charge' of an organisation, area or group of staff (Martin & Waring, 2013). With current changes

in the health care system the need to determine the needs of staff is important. The research entails the exploration of this 'what is' notion of registered nurse leadership in anticipation of considerations for practice to further enhance the leadership role of the RN. There is already a shift in this mindset to allow for transparency, communication and a more shared decision making capacity (Marles et al., 2015). How this works and what the role of the RN is, may further be discovered through the research being undertaken. One shift is the transactional leader who positively seeks to motivate employees through reward systems and decisions based on the discussions or transactions that takes place amongst leaders and colleagues to achieve work outcomes (Castle & Decker, 2011; Cummings et al., 2010; Hamstra et al., 2014). This places emphasis on greater communication and less unilateral decision making in the work environment.

A discussion of various leadership styles or theory is not representative of one being of more value than another in the residential aged care context, but rather each offering a different perspective on the way decisions are made and the resultant outcomes for staff and residents in the setting (Havig et al., 2011; Stanley, 2014). Research conducted by Havig et al. (2011) identified that task oriented leadership has a strong impact in the clinical work environments of residential aged care settings and this may be related to the 'employees' hierarchical levels'. This creates the notion of levels of decision making capacity in the work setting however does not preclude staff inclusion in the decision making process. In any leadership style reviewed from the literature the key concepts of decision making capacity, inclusion of staff, motivation, engagement and communication appear critical to successful staff retention, job satisfaction and positive resident outcomes (Anonson et al., 2014; Chenoweth et al., 2010; Pearson et al., 2007; Yun-Hee et al., 2013).

Within a clinical setting there will always be specific clinical nuances that require careful consideration and intelligence to ensure that decision making practice is in line with best practice standards and clinical expertise at the frontline of care (Baernholdt & Cottingham, 2011; Bender, Connelly, & Brown, 2013; Davidson & Elliott, 2006; Enterkin, Robb, & McLaren, 2013). In reviewing leadership in both definition and characteristics the notion of clinical leader appears. Moloney, Taylor and Ralph (2016, p.30) identified in a research study conducted in Australian aged care settings that 'nurses need to take a proactive leading role in prioritising evidence

based practice initiatives'. This proactive approach to leading requires the clinical leadership capacity of the RN to make decisions in clinical practice. Clinical leadership, not unlike the previous definitions of leadership, is both complex and multi-dimensional. It does, however, relate specifically within the clinical stream of care provision and decision making capacity particularly in evidenced-based practice decision making in clinical settings (Moloney et al., 2016; Stanley, 2014; Swanwick & McKimm, 2011).

2.5 THE REGISTERED NURSE AND CLINICAL LEADERSHIP

Nursing clinical leadership is about the leadership demonstrated within a nursing clinical setting. The practicality of nursing-oriented leadership is often viewed with respect to the clinical area of work and is known in the literature as clinical leadership (Stanley, 2014; Swanwick & McKimm, 2011; Walker et al., 2011; Williams, 2011). A defined clinical setting, a ward, residence, unit or house is where an RN conducts their work. An RN in these areas will lead their team in accordance with the clinical demand they meet each day. This demonstration of clinical leadership is seen by the RN in their clinical setting (ward, unit or residence) in the utilisation of decision making capacity in line with clinical needs, staff relations, and organisational capacity (Castle & Decker, 2011; Cummings et al., 2010; Stanley, 2014). The literature identifies the role of the RN in aged care as critical in fostering the collaborative relationships with aged care staff to achieve positive resident care outcomes (Anonson et al., 2014; Castle & Decker, 2011; Patrick, Spence Laschinger, Wong, & Finegan, 2011). To achieve this requires the ability to lead the clinical care team.

2.5.1 Defining Clinical Leadership

Definitions of clinical leadership have been debated in the literature with suggestions there are several parts to the definition (Howieson & Thiagarajah, 2011; Mannix et al., 2013; Martin & Waring, 2013; Stanley, 2006, 2008, 2014; Swanwick & McKimm, 2011). Successful leadership in health care is greater than defining and engaging a specific leadership style or trait. It is about understanding the environment, staff, and the complexities of the setting to be able to lead and understand the needs and requirements of all members of the team.

The literature highlights the difficulties in ascertaining a succinct definition of clinical leadership claiming that there are many concepts in the definition (Howieson & Thiagarajah, 2011; Jeon, Merlyn, et al., 2010; Stanley, 2006; Swanwick & McKimm, 2011). This is consistent with defining the broader term of leadership where complexity adds to the volume of definitions. However, it is clear that there is significant interest in clinical leadership and its meaning to nurses in the clinical environment. Howieson and Thiagarajah (2011), articulate that the term clinical leadership has a particular association to the RN as clinical leader. This clinical leader is a position about 'driving service improvement and the effective management of teams to provide excellence in resident/client care' (Howieson & Thiagarajah, 2011, p. 10). Consistent with a number of leadership styles this synopsis of clinical leadership provides a degree of ownership on all individuals in teams. Stanley (2008, p. 63), discusses a model of congruent leadership and affirms that it is 'congruent leadership that responds to challenges and critical problems with actions and activities in accordance with staff values and beliefs'.

Further studies identified clinical leadership as a process of leadership, and in practice it is in the demonstration of RN behaviours particularly in relation to their role (Baernholdt & Cottingham, 2011; Martin & Waring, 2013; Patrick et al., 2011; Stanley, 2014). This is an important feature as the inclusion of change agent, visionary and advocate for both the resident and the profession of nursing are vital components in the role of the RN in the residential aged care setting (Anderson, Issel, McDaniel & Reuben, 2003; Hurley & Hutchinson, 2013). An RN in this setting is often limited in their decision making capacity as the daily care and completion of regulatory assessments overshadows the vision and voice of nursing leadership (Angus & Nay, 2003; Jeon, Glasgow, et al., 2010). The restrictions of time and capacity are barriers for the RN given the volume of residents in their charge each shift (Castle & Decker, 2011; Tuckett, et al., 2011; Tuckett, Hughes, et al., 2009). Despite the best intent of the RN within residential aged care settings what is apparent is that often care is based on priority, reactivity to situations and resident events and not always on the planned prioritisation and leadership exhibited by the RN (Bellis, 2010; Castle & Decker, 2011; Tuckett, Parker, et al., 2009).

Clinical leadership is about care and care decisions and how staff is led within a health care organisation to meet shared visions, resident care and quality outcomes (Howieson & Thiagarajah, 2011; Stanley, 2008). These summations incorporate similarities to the transformational/relational and distributed theories of leadership and again articulate the necessity for greater than one person's involvement in decision making processes and highlight the need for clear and consistent communication channels (Berson & Halevy, 2014; Walker et al., 2011; Wilson et al., 2013).

The residential aged care sector is currently in the spotlight with an expanding aging population, a shift in care provision from aging in place to a more resident centred care approach, a decline in RNs in the sector and an increase in UHCWs and a strong consumer driven society (Bellis, 2010; Martinson & Berridge, 2014). The need for strong leadership is at the forefront in leading the success of residential aged care nursing into the future.

2.6 THE AGED CARE SETTING

The leadership role of the RN in the aged care setting is complex and much of the complexity is found in the environment and the human and physical context that the RN works in (Arnold & Boggs, 2013; Chen et al., 2011; Chenoweth et al., 2010; Huntington et al., 2011; Tuckett et al., 2011). The role is predominantly focussed on the care and social well-being of individuals as they age. Understanding the complexity of aging and what this means in context to the experience of RNs is important as it is this area that decision making and care coordination occurs and where the RN and their subsequent leadership capacity is seen.

2.6.1 The Aged Care Residents

To understand the leadership role of the RN in residential aged care it is important to know more about the residents in care. Australia has one of the highest life expectancy rates in the world (UN, 2008). Statistics indicate that in '1901 only 4 percent of the Australian population were aged 65 years and older' (ABS, 2011, p. 5). Current statistics indicate that in 2010 the proportion of individuals in Australia over the age of 65 years had increased to '15.5 percent of the population with a further projected increase to between 21 and 23 percent by 2041' (ABS, 2011, p. 5).

Defining the term 'aged' is somewhat difficult and complex (Brownie & Horstmanshof, 2012; Sonaware, 2015; WHO, 2015). The leadership provided by the RN to the team of staff caring for individuals as they age and as the complexity of aging and care provision becomes apparent, is a key concept in the role. The role entails the leadership needed to coordinate care and to coordinate staff in care provision to individuals at a time in the Australian context of increasing age and of increasing complexity (Hill, Kolanowski, Milone-Nuzzo, & Yevchak, 2011; McKee et al., 2013).

The reality is that aging is a natural process where changes to an individual's health, physique and outlook may vary or where an alteration in an individual's mindset may shift and as a result the individual may require a move to a residential aged care complex. Care of this group of individuals within populations also construes negative concepts with terminology to describe both the person and the setting, inclusive of aged care, respite care and care of the older or elderly person (Brownie & Horstmanshof, 2012; Ibrahim et al., 2014). The care of individuals in the residential aged care setting is viewed as one of social care, and one requiring minimalistic numbers of RN staff within the organisational context. In Australia, centres of care are referred to as residential aged care facilities or nursing homes (Goss, 2008; Health Workforce Australia, 2012; King et al., 2013).

2.6.2 Care Provision

The type of care is usually distinguished by the funding model and the level of care that an individual is assessed as requiring (Goss, 2008; King et al., 2013). Angus and Nay (2003) and Reynolds (2009) discuss the economic burden and the criticality in needing a change in the sector, with care requirements assessed in terms of resources required. In this analogy the terminology of 'resources' is seen as the assessment conducted on individuals as requiring 'high care' or 'low care' needs (Aged Care Act, 1997). This assessment process results in what appears as a connection broadly based within the components of a medical based non-resident focussed approach, to facilitating care around identified physical or psychological issues that present (Angus & Nay, 2003; Baines et al., 2014; Bishop, 2013). The legislative framework and guiding principles surrounding this includes the provision of a RN in the staffing model where high care residents are present (Aged Care Act,

1997). This complexity also relates to a more autocratic or servant based approach to leadership where care is provided based on a process of doing cares and providing social activity (Angus & Nay, 2003; Avolio & Bass, 1999; Barbuto et al., 2014; de Waal & Sivro, 2012). Within the current residential aged care funding model, an improvement in a residents health status results in a potential reduction in attributable funding to a setting (Angus & Nay, 2003; Aged Care Act, 1997). This negative funding model is attributed to a so-called reduction in care requirements rather than an improved quality of life outcome for a resident. This reduction in funding is a negative incentive to improve the health status of those in residential aged care settings and goes against the ethos of the care practices of RNs. The incentive to provide health and well-being care initiatives is further eroded or made more complex to achieve without accessibility to optimal funding options for care provision and for quality of life outcomes. It is this model that equates well with the notion of 'to be old is to be ill' (Stewart, Chipperfield, Perry & Weiner, 2012, p. 881). Research conducted by Tuckett et al. (2011, p. 451) in Queensland Australia highlights that nursing graduates do not enter aged care nursing as a career choice as it is considered 'poorly funded where old people and aged care are socially disregarded'. This statement inherently links with previous discussions relating to the negative construct of aging.

It is clear from the literature that Australians are living longer and aging in its entirety is becoming an economic health concern (Angus & Nay, 2003; Baines et al., 2014). The literature identifies a connection between the care of persons with chronic manageable medical conditions and age, and the reality presents with increases in medical technology and therapeutic medications and treatments, that people are living longer (Baines et al., 2014; Caspar & O'Rourke, 2008; Goss, 2008; King et al., 2013). This longevity does impact the level of care and needs of people as they age. Nevertheless, there appears to be an over medicalisation of the system and aging is seen more as a disease to be treated than a normal part of the human aging process (Anderson & Reuben, 1998; Bishop, 2013; Walmsley & McCormack, 2015). This, coupled with the negative views of aging creates complexities and preconceived notions within the system of residential aged care in Australia. This negativity has an impact on those working in the sector and within the population more broadly with consumer advocacy groups and consumers of the services. To

understand how this negativity and historical perspective has been ascertained it is important to first gain an understanding of how the aged care sector that RNs work in has developed across time in Australia's history.

2.7 THE HISTORICAL UNDERPINNINGS OF THE AGED CARE SECTOR

A review of the socio-political and historical underpinnings of the aged care sector in Australia identifies an embedded link with the medical model of care. The system in its evolution has undergone criticism and reform that continues to the current day (Angus & Nay, 2003; Kendig & Duckett, 2001). The historical premise in Australia was that the healthy older person would live with their family and the sick would attend hospital for treatment as required.

2.7.1 Socio-political-historical Background

With less than 100 years' history as an independent country, the 1950s and '60s saw the Australian government policy developed further by the Menzies government acknowledging aging as not a priority within social policy development (Kendig et al., 2010; Kendig & Duckett, 2001). Kendig et al., (2010) discussed the use of the 'terms 'elderly' and 'pensioners' as it was this terminology that became increasingly perceived as synonyms. The Hawke-Keating led Australian government of the 1990s began to see aged care as a priority (Kendig & Duckett, 2001). With the hallmarks of aged care linked explicitly with acute hospital care, the literature identifies the idealistic medical model as a static feature of the aged care system (Bishop, 2013; Caspar & O'Rourke, 2008; Walmsley & McCormack, 2015). The role of the RN was seen as one of a care coordinator or leader in the setting to guide and support volunteers or unskilled workers in care provision (Bishop, 2013; Caspar & O'Rourke, 2008; Kendig & Duckett, 2001; Walmsley & McCormack, 2015).

In 2010, the Gillard government commissioned an inquiry into the aged care system as escalating costs in the industry and a noted aging population where numbers requiring services continued to rise (Hughes, 2011; King et al., 2013; Productivity Commission 2011a, 2011b). Statistics indicate that the total health and residential aged care expenditure in Australia is projected to increase by '189 percent in the period 2003 to 2033' (Goss, 2008, p. 11). This further increases the perceived

burdens and challenges to a system already under pressure and to the RNs who lead care in this setting.

It is these challenges that led to discussions and policy changes in the sector. This, coupled with a greater consumer led society; impending staffing shortages particularly within the capacity to recruit and retain RNs in the sector, and calls from within the health industry has noted the need for change (Chenoweth et al., 2010; Hayes et al., 2012; King et al., 2013; Tuckett et al., 2011). It is estimated that figures relating to older Australians in future years will exponentially climb with one Australian Bureau of Statistics projection outlining a shift in 2014 from 1514 per 100 000 to 2276 per 100 000 in 2054 (ABS, 2014). These statistics indicate the significance of the demand for aged care services is high with further estimated increases (ABS, 2014).

The data from the ABS (2014) raises concern within a system of residential aged care services that currently faces difficulties in fiscal resourcing, staffing and in nursing recognition as a specialisation within practice (Castle & Engberg, 2008; Hodgkinson et al., 2011; Pearson, Schultz, et al., 2006). The literature also outlines the expense to the system of staffing models and a growing need for the management of chronic illness, palliative care and dementia care (Abbey, Froggatt, Parker, & Abbey, 2006; Barbosa, Nolan, Sousa, & Figueiredo, 2015; Wong et al., 2013).

Government policy continues with reform and regulation as an ongoing paradigm. In 2010 the commissioning of an Inquiry into Aged Care in Australia called for a strategy to develop options for redesigning the aged care system (Hughes, 2011; Productivity Commission, 2011a, 2011b). *The Productivity Commission Report* (2011, p. 22), indicated that the 'two demographic growth factors in Australia included the growing aging population and the absolute increase in the general population'. Further to this, it is estimated that 'dementia has the projected increase of 364 percent' (Goss, 2008, p. 6) in the coming twenty-five years. The literature indicates explicitly the need for close consideration into the future needs of the workforce in aged care services both within the community and in residential aged care settings (DoHA, 2012; Goss, 2008; Productivity Commission 2011a, 2011b; Segal & Bolton, 2009). Never has there been a more strategic time

for the leadership role of the RN in residential aged care to be at the forefront of government discussions.

2.7.2 Future Projections

Linked with the discussions on the definition of aging is the Australian Bureau of Statistics (2013), data sets for those individuals greater than 65 years. This data source is indicative of an increase in service requirements with significant increases in the aged population future forecast projections. These projections are presented in Table 1, and provide 2013 data pertaining to the number of older Australians comparatively with projections for each decade until 2054. The dataset identifies an exponential rise in the older Australian population.

Table 1: 2013 data pertaining to the number of older Australians with projected forecasts until 2054

Age group	2014	2024	2034	2044	2054
	Number of older Australians ('000)				
65 years +	3,451	4,737	6,064	7,140	8,392
70 years +	2,332	3,364	4,552	5,486	6,307
75 years +	1,514	2,194	3,107	3,874	4,476
80 years +	904	1,224	1,887	2,519	2,984
85 years +	455	595	955	1,349	1,662
90 years +	161	229	339	552	754
Total Population	23,524	27,690	31,665	35,401	39,036
	Per cent of total population				
65 years +	14.7	17.1	19.2	20.2	21.5
70 years +	9.9	12.1	14.4	15.5	16.2
75 years +	6.4	7.9	9.8	10.9	11.5
80 years +	3.8	4.4	6.0	7.1	7.6
85 years +	1.9	2.1	3.0	3.8	4.3
90 years +	0.7	0.8	1.1	1.6	1.9

Source: (ABS, 2013) ABS Population *Projections*, Australia, 2012 to 2100, online summary (Cat. No. 3222.0) series B (2013)

With these projections in sight, the Australian government commissioned further work in the area of aged care reform. The *Australian Aged Care Reform Package* was implemented in 1997 with further enhancements in 2012 with the *Living Longer Living Better Package* (DoHA, 2012). It is this reform that appears to have driven significant change within aged care nursing practice in Australia. The 2012 reform has multiple components inclusive of 'support in the home, better

access to residential care, more support for those with dementia and strengthening the aged care workforce' (DoHA, 2011, p. 15). The economic drivers in the aged care sector are significant, with a major concern for managers surrounding the increasing rates of pay of RNs, and the ability to appropriately recruit staff into the sector (Havig et al., 2011; Hodgkinson et al., 2011; Tuckett et al., 2011).

2.8 STAFFING MODELS IN THE RESIDENTIAL AGED CARE SECTOR

Contrary to the needs arising in the literature surrounding the ageing population and the resultant social and health care needs, aged care facilities have eliminated staff positions particularly with RN employees and implemented service cuts due to the corresponding reduced levels of funding provided (Hughes, 2011; Jeon, Glasgow et al., 2010). Staffing models in the residential aged care setting entail the employment of RNs, EENs and UHCWs. Alternatives to RN employment options are considered by aged care facilities (Hugo et al., 2009; King et al., 2013). These include the utilisation of the position of the medication endorsed EEN (King et al., 2013 Tuckett et al., 2011). This role with its advanced scope and capacity has enabled the retention of a qualified nurse on shift, where RN options have been limited (Tuckett et al., 2011). Although a specific scope of practice is inherent in both the role of the RN and the EEN, the employment capacity in the aged care sector sees the inclusion of both roles in leading teams (Jacob, Barnett, & McKenna, 2013; Milson-Hawke & Higgins, 2003). The complexity and difficulties confronted with this are the inability in the EEN registration standards to assess and evaluate care (Nursing and Midwifery Board of Australia, 2016a, 2016b), as this remains the obligation of the RN. Further to this, the business economic driver sees the fundamentals of care provided in residential aged care settings being completed by UHCWs, supported by an RN or EEN where care is complex or skills greater than those of basic hygiene, mobility or dietary support are required (Pennington, Scott, & Magilvy, 2003; Venturato & Drew, 2010). The importance of the leadership role of the RN is key in the coordination and evaluation of care requirements. It is the key role evident for the accountability of care provision within the sector.

A qualitative research project conducted in Queensland into the issues surrounding the aged care workplace identified that aged care nurses were concerned with 'labour – characteristics, condition, load and division' (Tuckett et al., 2011, p.

448). The research further articulated labour characteristics to be inclusive of insufficient nurses and insufficient skilled labour, and the resultant conditions of employment that flow from these noted insufficiencies (Tuckett et al., 2011). Coupled with this inadequacy in skilled labour is the known wage disparity that exists within the sector in comparison to other areas of nursing practice (Segal & Bolton, 2009; Tuckett et al., 2011). Wages in the aged care sector are less than those in other nursing specialities, particularly those in the acute care sector, compounding concerns in RN recruitment opportunities, and as a consequence RN leadership in the aged care sector (Segal & Bolton, 2009; Tuckett et al., 2011). This wage disparity is linked with the historical perspectives of aged care in Australia and the legislative guidelines linked inextricably to the funding models that govern the sector.

2.8.1 Aged Care Regulation

Regulation of the aged care sector is monitored through compliance standards, auditing and the submission of compliance reports. Reforms in Australia have further generated a number of compliance standards that must be maintained (Angus & Nay, 2003). Within these requirements there are four broad Standards with a further 44 expected outcomes from across the breadth of the four Standards (Aged Care Act, 1997; DoHA, 2011). Residential aged care settings must comply with all 44 expected outcomes at all times, and settings are audited at regular intervals to ensure compliance (Aged Care Act, 1997; DoHA, 2006; Hugo et al., 2009). Compliance standards are inclusive of the need to maintain logs and documentation of the achievement of compliance. It is a normal expectation that the RN will lead the compliance process within settings (King et al., 2013).

The RN applying these standards must aim to ensure a high quality of care. In the residential aged care setting however the RN must also lead others to ensure an environment that meets standards of compliance whilst juggling to meet individual holistic care needs of the residents and their expectations as a consumer of the service (Angus & Nay, 2003; DoHA, 2006; Hugo et al., 2009). The literature does outline the consumer focus of care requirements in this setting and the resulting government policies place focus on the socialisation of individuals as they age. The impact of this consumer focus and the implications of the leadership role of the RN require greater understanding.

2.9 RESIDENT CENTRED CARE

Government policy now calls on providers to acknowledge and implement care that is resident centred (Hugo et al., 2009; Ibrahim et al., 2014; Lynch et al., 2011). This has led to the development of a social care model in existing aged care settings and acknowledges the increased usage of UHCWs (ABS, 2014; King et al., 2013). Idealistically this model is focussed on enjoying life and participation in socialisation activities to combat elements of isolation and loneliness. This concept is a positive venture and one that is at the fore of personal choice in life. It is a concept that requires balance between the required medical intervention and care requirements of an individual with the notion of healthy aging and a resident centred approach (Herdman, 2002; King et al., 2013). The notion comes with complexity and in itself creates further intricacies within the residential aged care sector. The change from the known medicalisation of the aged care industry or *'aging in place'* to one of a more social care model *'resident centred care',* directly influences the environment where the older person resides and the workplace focus of the RN in such a setting (Herdman, 2002; Hugo et al., 2009; King et al., 2013).

What is needed and supported in the literature is the acknowledgement and action from political drivers to support the aging population, and connect with improved management of the complexity of chronic illnesses in this model of care (Hugo et al., 2009; Ibrahim et al., 2014; Kendig et al., 2010). The leadership role of the RN in leading the required care, monitoring residents and the evaluation of interventions, is important (Stanley, 2008; Swearingen, 2004). The literature speaks highly of futuristic models that address the system and engages the resident but acknowledges and respects the staff and the RN in the coordination of the complexities of care (Hill et al., 2011; McKee et al., 2013). Stewart, Georgiou, and Westbrook (2013) discuss the notion that many facilities attempt to provide care surrounding this resident centred approach. However restrictive funding and staffing options coupled with building layout and design similar to older models of care, place restrictions on the ability to achieve a true resident centred approach.

Within Australia, these attempts to foster a shift toward more social care oriented models of care that seek more of an individualised approach create enormous challenges. It is also these interventions that may result in improvements

in health status and the subsequent reductions in funding rather than reward for efforts achieved in this model (Angus & Nay, 2003; Segal & Bolton, 2009).

The change in care model also idealistically shifts focus from the origins of care provided by RNs where bureaucratic, hierarchical, military like systems have existed to one of a more holistic approach to care, from and with an individual (Hughes, 2011; Hurley & Hutchinson, 2013; Klein et al., 2006). This shift logically affects the leadership styles and presentations in settings. This, linked with an increasing number of regulatory standards prevails, and the result is a complex interwoven system of care and social interaction, of consumer input, fiscal resourcing and regulation (Angus & Nay, 2003; Bellis, 2010; Hughes, 2011). Residential aged care provision remains a national concern to consumers and the healthcare industry (Bellis, 2010; Hurley & Hutchinson, 2013). This is despite the strong regulatory compliance and care standards that have been introduced into the sector (Bellis, 2010; Forbes-Thompson et al., 2006; Hurley & Hutchinson, 2013).

Authentic resident centred care is expressed by Bishop (2013) where discussions are based around the importance of skills, knowledge and the effort of workers on the frontline. It is the commitment and communication combined with the skill and knowledge that builds a successful resident centred approach (Bishop, 2013; Duffield et al., 2014; Lynch et al., 2011). This places the roles of all workers in the aged care industry in scrutiny, however with accountability still within the realms of the role of the RN (Duffield et al., 2014; Maddox, 2014).

2.9.1 Nursing Care and Promoting Independence

A basic objective of aged care nursing is to permit aged care residents to have as much independence of choice in their lives as is possible within the limitations of life in a residential aged care setting (Brownie & Horstmanshof, 2012; Lynch et al., 2011). The ability to achieve this is dependent on both organisational objectives and the leadership from within, and by the staff in the facility. At the core of resident centred care is the relationship between aged care staff and the resident (Brownie & Horstmanshof, 2012). There are a number of basic characteristics that support the implementation of resident centred care and these include strong leadership, collaborative decision making processes, teamwork and continuous improvement

(Brownie & Horstmanshof, 2012; Chenoweth et al., 2010; Yun-Hee, Merlyn, & Chenoweth, 2010; Yun-Hee et al., 2013).

2.10 STAFF EMPLOYMENT IN THE RESIDENTIAL AGED CARE SECTOR

Understanding the complexities of the nursing workforce combined with an unregulated workforce in aged care settings provides caution and complexity (Bellis, 2010; Goss, 2008; King et al., 2013). The *Productivity Commission Report* (2011a) quantitatively identified that there is an increasing trend in employing less skilled staff in residential aged care facilities. King et al. (2013, p. 8), identified that 'total employment in residential aged care for 2012 is estimated to be 202, 344, an increase by 29 per cent since 2003.' As shown in Table 2 there is an identified increase in the residential care workforce overall, however a decline in the RN and EEN capacity. It is cited in the literature that the effect of this transition may impact negatively on 'positive patient outcomes, greater responsibility and leadership requirements of the RN and a resultant increase in care accountability' (King et al., 2013, p. 9).

Table 2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated headcount and per cent)

Occupation	2003	2007	2012
Nurse Practitioner (NP)	n/a	n/a	294 (0.2)
RN (RN)	24,019 (21.0)	22,399 (16.8)	21,916 (14.9)
EEN (EN)	15,604 (13.1)	16,293 (12.2)	16,915 (11.5)
Personal Care Attendant (PCA)	67,143 (58.5)	84,746 (63.6)	100,312 (68.2)
Total number of employees (headcount) (%)	106 766 (92.6)	123 438 (92.6)	139 143 (94.6) 139 437 (94.8) with addition of NP

Source: King et al., 2013, p. 9.

Table 2 demonstrates that since 2007 the number of RNs in residential aged care settings has fallen by 483 employees and the share of the direct care workforce has decreased from 16.8 per cent to 14.9 per cent. There is also a small increase in EEN numbers although there remains a decrease in EENs as a proportion of the direct care workforce, with a slight decrease from 12.2 per cent to 11.5 per cent. It is in the visibility of this declining number of RNs and EENs operationally that

residential aged care facilities place a greater degree of accountability in the role of the RNs that remain in the setting. This is seen with facilities only able to afford the luxury of a single RN working each shift for significant numbers of residents, coinciding with ongoing recruitment and retention struggles in the sector (Chenoweth et al., 2010; Duffield et al., 2014; Mohle, 2011; Tuckett et al., 2011).

2.10.1 The Registered Nurse

The RN is a university prepared graduate that is governed in Australia by the Australian Health Practitioners Regulation Authority (NMBA, 2016b). There may, in some residential aged care organisations, be a number of older RNs who completed hospital based qualifications some years ago. In Australia, all RNs must annually complete the legislative requirements for registration to enable them to practice as a RN (AHPRA, 2015). As a registered practitioner there are a number of key competency areas where a RN's practice must be demonstrated, and these encompass areas of care delivery, assessment, evaluation, education, leadership, ethics and governance (NMBA, 2016b). The role entails the responsibility and accountability surrounding the care requirements and assessment of an aging resident. This responsibility is further increased given the reality that frequently only one RN is on shift in an aged care facility and support mechanisms rely heavily on emergency services, or on call staff when incidences or events occur (Castle & Engberg, 2008; Chenoweth et al., 2010; Duffield et al., 2014; Mohle, 2011; Tuckett et al., 2011).

As a result, the residential aged care setting faces increasing pressures to meet both the clinical demand and the ability to recruit qualified and motivated aged care specialist RN staff. Research by Venturato et al. (2007) explored the employment experiences of RNs in long term aged care services and aspects of difficulties with recruitment and retention within the aged care nursing domain. These authors determined that the RNs appear 'in the middle of a system that places responsibility yet limits autonomy, demands high quality care, yet limits resources and seeks to promote the rights of older people, through a system that fails to recognise their individual worth' (Venturato et al., 2007, p. 672).

The literature surrounding the scope of the RN commonly articulates the role as the support and link between the care providers, families and the organisations

management (Anderson & Reuben, 1998; De Bellis et al., 2013; Huntington et al., 2011; Tuckett, Henwood, Oliffe, Kolbe-Alexander, & Kim, 2015; Tuckett, Hughes, et al., 2009). Research from a variety of sources also indicates the RN as a vital role in providing the fundamental link between management, care services, resident and family liaisons through and within these channels (Anderson et al., 2003; Crilly, Chaboyer, & Wallis, 2012; Scott-Cawiezell et al., 2004).

Likewise, the role of the RN requires the discretion, knowledge and expertise to know when a resident, their family or a staff member is in need. The role includes liaison with staff, families, visiting medical and allied health practitioners and links information to and from management personnel within the organisation (Castle & Engberg, 2008; Marcella & Kelley, 2015). The RNs have input into care decisions at a policy level, manage staff of varying levels of education and ability, and are the direct communication portal to the resident's medical practitioner. However, they are often not involved in the more strategic decision making processes that look at strategies aligned with the shift to resident focussed care (Drescher et al., 2014). Nor are they always involved in the hands on care that occurs with residents each day. It is identified in the literature that with the increasing demand for palliative care services, more complex wound management, enteral feeding requirements and the specialty care of those with dementia, the hands on role of the RN is required, making each shift complex and demanding with a need to set the tempo between leading and doing (Hasson et al., 2008; Johnson et al., 2009). Martin and Waring (2013) and Wilson et al. (2013), see the RN as a scarce resource responsible and accountable for not only the planning and supervision of care but importantly as a clinical leader.

2.10.2 The Endorsed Enrolled Nurse

Working with the RN and supporting the roles of both RNs and the UHCWs is the EEN. The EEN, similarly to the RN is registered to practice in accordance with the scope of practice of an EEN or Division 2 nurse within Australia (AHPRA, 2015). The position is defined by the legislative obligations of registration in Australia (AHPRA, 2015; NMBA, 2016a). The competency standards pertaining to the EEN are similar in some context to that of an RN however explicitly exclude

areas of assessment and evaluation relating to a resident or patient in the EEN's care (NMBA, 2016a).

The EEN education programs in Australia are designed to develop skills in the provision of basic care, comfort measures and the support of individuals and groups (Milson-Hawke & Higgins, 2003). The role is somewhat confusing with the literature identifying the reality of role boundaries and facility driven resident care demands on the EEN rather than the RN (Kenny & Duckett, 2005; Milson-Hawke & Higgins, 2003). The literature identifies trends in the manipulation of the skill grade mix of RNs and EENs as part of the cost saving mechanisms of facilities (Milson-Hawke & Higgins, 2003). The EEN in a number of instances being the 'registered' individual on shift with the on call capacity for an RN as deemed relevant (Milson-Hawke & Higgins, 2003). Jacob et al. (2013), and Kenny and Duckett (2005), further identify the disillusionment and role erosion experienced by EENs as they are required to lead a team in the delivery of care, but are excluded from the assessment and decision making process.

Jacob et al. (2013), and Milson-Hawke and Higgins (2003) outline the challenges faced by EENs in the aged care setting and affirm they are attributable to the need to lead a team, where role erosion and the growing employment capacity of the UHCW is seen. It is in this category that the EEN appears to provide fewer hands on resident care hours and more team supervision and specific skills or tasks such as medication administration and wound management. For the EEN, the ability to work in the standards of professional practice (NMBA, 2016a) whilst providing the care and team supervision allocated to them, is complex and further exacerbates the concepts of role ambiguity discussed in the literature (Jacob et al., 2013; Kenny & Duckett, 2005; Milson-Hawke & Higgins 2003). The RN in the aged care setting provides the leadership, guidance and mentorship to the EENs and the support and direction to both the EEN and UHCW. However in many respects this leadership and mentorship is an expectation rather than a process of understanding the role explicitly.

2.10.3 The Unregulated Health Care Worker

There are many titles used in health to describe the title and role of the UHCW. These include health care assistants, nursing assistants, personal care workers, personal care attendants, health care workers, nursing aide, nursing orderly or attendant or assistant in nursing. Irrespective of title, the historical role has been inclusive of hands on care provision relating to the activities of daily living inclusive of feeding, mobility, hygiene, toileting and social care (ABS, 2014; Huai-Ting, Teresa Jeo-Chen, & Li, 2008). The literature indicates that the UHCW comprised around 50 – 60 per cent of the staff in nursing homes in 2003 in Australia, with the percentage increasing each year to approximately 70 percent in 2014 (ABS, 2014; Milson-Hawke & Higgins, 2003). The only mandatory employment requirement for an UHCW is a National Police Check in an effort to minimise elder abuse within aged care settings in Australia. This check is not only explicit to the UHCW but to all employees and volunteers in the sector.

Employment activities range from the completion of activities of daily living with residents, mobility and safety parameters of care, to cleaning, and meal preparation and delivery (Barry, Brannon, & Mor, 2005; Castle & Engberg, 2008; Dill & Cagle, 2010; Pennington et al., 2003). There is a mixture of reporting accountabilities within the role from direct reports back to the RN to alternative reporting mechanisms to support service managers or facility or operations managers. The level of training that UHCWs receive can vary from facility to facility. The literature discusses the educational level and outlines variances from short courses, to vocational training certificates or associate diplomas (Milson-Hawke & Higgins, 2003; Rudy, Polomano, Murray, Henry, & Marine, 2007). The educational courses completed are not inclusive of areas relating to clinical decision making, anatomy or physiology, diseases or pharmacology. In many residential aged care settings the administration of medications and responding to questions about health and social care requirements occurs (Milson-Hawke & Higgins, 2003). The educational standard is established through individual residential aged care employers. For many organisations the requirement is to have completed a Certificate III in Disability Services or its equivalent. For other employers the desire to care and the willingness to work in the setting is the minimal requirement for UHCW employees.

In 2014 the Australian government outlined draft recommendations with respect to a code of conduct for unregulated practitioners (COAG, 2015). Inclusive within this Code is the role of the UHCW. The Code outlines a set of practice standards expected of UHCW in health care settings. These are prescribed not as a regulatory force rather as an incorporated practice guideline (COAG, 2015). The guideline also outlines a reporting by variance process for practices outside the expected standards (COAG, 2015). This draft Code has been trialled in both Queensland and South Australia. Duffield et al. (2014) further articulates that this Code has come at a critical time in the work life of UHCWs as their role has extended to now include activities previously undertaken by licensed practitioners such as EENs and RNs. The Code elaborates on 17 key areas of conduct to which an unregistered practitioner must adhere (COAG, 2015). These range from the provision of safe care and ethical practice, fitness to practice, record keeping, insurance indemnity matters, and to being responsive to adverse events (COAG, 2015). The Code is not regulated at present and is dependent on individual organisations to maintain human resource practices to manage any individual staff variances or breaches. The leadership role of the RN is seen as the key role in the monitoring of the practices of the UHCW and also of providing guidance, tasks and responsibilities to UHCWs in the residential aged care setting (Duffield et al., 2014; Dwyer, 2011). Aims to ensure practice standards are maintained at high levels are sought by employers and consequently, the RN is responsible in settings for education and practice standards relating to the practical application of the work conducted (Baines et al., 2014; Duffield et al., 2014; Germain & Cummings, 2010; Pearson et al., 2007).

2.11 THE ART AND PRACTICE OF COMMUNICATION

Irrespective of leadership style one concept was clear and transparent in all, of the literature, this being the art and practice of communication. Communication was viewed in all areas of leadership practice as a key ingredient, an essential concept in the basic foundations of the practice of nursing (Acree, 2006; Avolio & Bass, 1999; Dignam et al., 2012; NMBA, 2016b; Stanley, 2014). Communication is a quality of good leadership (Asencio et al., 2012; Lanzoni & Meirelles, 2011; Scott-Cawiezell et al., 2004; Stanley, 2014). Communication can be defined as the 'creation or exchange of understanding between a sender and a receiver' (Forbes-

Thompson et al., 2006, p. 936). Further to this succinct definition, communication in nursing refers to the act of exchanging information by speaking, writing or using some other medium (Arnold & Boggs, 2013). The dimensions of communication include openness, accuracy, timeliness, understanding and effectiveness (Kiernan, 2015). Openness and accuracy involves the communication between staff to say what they mean without fear of repercussion or reprisal whilst ensuring the accuracy or objectivity and professionalism in message conveyance (Arnold & Boggs, 2013; Forbes-Thompson et al., 2006; Garon, 2012). The importance of the timeliness of the message sent adds to the success of the conveyance of the message intent. How a message is sent, in what capacity and communication style effects how the message is received and interpreted (Kiernan, 2015). For the RN it is about sharing dialogue but more about seeing what is happening, feeling the mood and reading the non-verbals to gauge an understanding of the work environment and the individual resident's situation (Scott-Cawiezell et al., 2004; Kiernan, 2015; Perrin, Stanley & Taylor, 2015).

2.11.1 Communications in Clinical Teams

The discussions surrounding communication highlights that it is not about one person or the exchange of information between only two people but rather the complex dynamic of both verbal and non-verbal communication of words, mood, atmosphere and information that creates a team within residential aged care nursing (Arnold & Boggs, 2013; Garon, 2012; Zwarenstein et al., 2007) . It is about working in a team, and for a team. It is the RN in the aged care setting that has the enormous task of working with staff, with managers, with external medical and allied health staff and with families (Arnold & Boggs, 2013; Garon, 2012; Perrin et al., 2015). The coordination of the care for, and in these areas is complex yet pivotal to the role of the RN. It is the coordination in, and between teams that becomes critical each shift, as communication is the cornerstone concept to successful team management (Reeves & Macmillan, 2010; Miers & Pollard, 2009; Scott-Cawiezell et al., 2004). Effective communication provides the team with fundamentals of trust, respect, shared knowledge and collaborative care decisions (Asencio et al., 2012; Lanzoni & Meirelles, 2011).

2.11.2 Communication and Clinical Leadership

Communication and the ability to engage and include staff in decision making appears to be key components of the role of the RN leader (Johnson & Ezekielian, 2014; Kadu & Stolee, 2015). In some ways it is about enabling an individual in the workplace to be involved, engaged, practice not only skills but also the ability to decide in the team, on care decisions. In the aged care setting it is the RN that asserts the leadership role from the frontline to the resident to more strategically within the higher management positions (Hurley & Hutchinson, 2013; Rokstad et al., 2015; Salanova, Lorente, Chambel, & Martinez, 2011). It is the communication from and within the RN role that provides the link between all members of the broader team (Anderson et al., 2003; Berson & Halevy, 2014; Castle & Decker, 2011). It is this leadership that ensures a flow of information or creates a dissonance between the groups and it is through communication that the needs of the resident are both heard and delegated.

Delegation is a key role within the scope and function of the RN (Asencio et al., 2012; Bergman et al., 2012; Klein et al., 2006; Wang et al., 2014). The RN in the residential aged care setting is the person that determines a course of action, notifies a doctor when a decline in health is noted, and monitors the resident when a palliative care regime is implemented. The role is large and the tasks associated are broad however it is the overarching leadership that is required to ensure that each member of the team completes the care and provides the communication of what is happening to this central point, the RN (Miers & Pollard, 2009; Reeves & Macmillan, 2010 Scott-Cawiezell et al., 2004).

Models of care that encourage participation at all levels provide care to residents that is focussed, that relates to the physical and social domains, and that is relevant and responsive to the needs of the resident. This distributed, yet also transformational approach to leading within a setting encourages, informs and engages a team in the work required (Dearmon et al., 2015; Stout & Weeg, 2014; Tomlinson, 2012). The ability of a team and a leader to capture the essence of a formal leader with the drive and the ability to distribute or delegate to those to enact what is required for a resident is critical Asencio et al., 2012; Bergman et al., 2012).

From a broader governance perspective the role of the RN is seen as the go to person, the one where decision making occurs (Supovitz & Tognatta 2013). It is the RN that informally holds the power balance or in some settings formally holds the position of leader (Anderson & Reuben, 1998; MacPhee, Skelton-Green, Bouthillette & Suryaprakash, 2012; Supovitz & Tognatta 2013). The transparency and performance within the role is determined in the communication, the power balance held and the influence on the staff within the team (Kanter, 1977, 1981, 1994). The importance of the role is large and the effect on staff and residents cannot be underestimated. For this reason, the literature reviewed supports this notion and encapsulates the need to provide the necessary education to empower individuals in an organisation (Klein et al., 2006; Martin, Beech, MacIntosh, & Bushfield, 2015). It is through good communication, teamwork and leadership that organisational performance and resident care improvements are seen (Begley, 2009; Bowers, Nijman, Simpson, & Jones, 2011; Davies, 2013; Garon, 2012; Tyler & Parker, 2011). To suitably prepare RNs for leadership roles in the residential aged care setting, education and training are imperative (Burgess & Patton Curry, 2014; Gifford, Davies, Tourangeau, & Lefebre, 2011).

2.11.3 Staff Education in Practice

Education at an organisational level is vital as it is through this avenue that the RN is able to provide correct and safe ways for care provision (Bajnok, Puddester, MacDonald, Archibald, & Kuhl, 2012; Dignam et al., 2012; Hallinger, 2003; Williamson, 2005; Yun-Hee, 2014). This is of particular relevance with high proportions of UHCWs in the residential aged care workforce. (King et al., 2013). The complexity in this educational stance is in the time, capacity and ability of the RN to conduct and follow-up on educational activities (Williamson, 2005; Yun-Hee, 2014). Education and training occurs in-house, that is, within facilities and via the role of the RN. This form of education relates to what is needed to care for residents, how the education is provided, and when and by what means the RN is able to provide the education.

Establishing priority areas to focus education and training is key. In the residential aged care setting a high degree of regulation, audit and compliance exists (Angus & Nay, 2003; DoHA, 2006; Hugo et al., 2009). It is in these areas that

ongoing education and training is provided to ensure compliance to standards is maintained. The residential aged care setting is also a workplace of diversity with increases in residents with chronic illness, palliative care and dementia-specific care requirements (Abbey et al., 2006; Agar et al., 2012; Hasson et al., 2008; Johnson et al., 2009). Establishing suitable and appropriate education sessions and programs is key to ensuring key concepts in care provision are met. The RN is the catalyst, the educator and the care coordinator in many settings resulting in education tailored to the specific needs of both staff and the organisation (Bajnok et al., 2012; Cooke, Moyle, Venturato, Walters & Kinnane 2014; De Bellis et al., 2013; Dignam et al., 2012; Hallinger, 2013).

Research conducted by Cooke et al. (2014) outlines the importance of caring for individuals with dementia. The research conducted outlines the importance of education provided to staff employed particularly within the role of UHCWs to assist in the quality of care provided and resultant quality resident outcomes (Cooke et al., 2014). The research articulates the use of a protocol with real life problem-centred initiatives to engage and educate the predominantly unskilled workforce (Cooke et al., 2014). Education in dementia care is critical with the rising numbers of residents requiring this specific care. The leadership required from the RN is foundational to staff and provides the safety in care initiatives, and the development and implementation of strategies to assist residents. RNs provide key components of the practical application of strategies and initiatives to assist in caring for those with a diagnosis of dementia (Barbosa et al., 2015; Rokstad et al., 2015; Walmsley & McCormack, 2014). The education strategies used by the RN in the residential aged care setting to improve resident approaches to the management of behaviours, distractive and memory recognition activities and with understanding the disease state and the implications in care from a staff perspective, are important (Barbosa et al., 2015; Cooke et al., 2014; Rokstad et al., 2015). It is with this education and awareness that UHCWs are able to be the eyes and ears on the ground to recognise and report key information to the RN.

A further area of education is in palliative care requirements. Marcella and Kelley (2015) conducted research focussing on quality of life for people dying in residential aged care settings. What is known is that palliative care is a specialised area of care, with UHCWs and nursing staff all requiring training and education for

the delivery of such care (Marcella & Kelley, 2015). Important in this is the support for grief, loss and bereavement from a staff member's perspective as it is well established that residents are known and familiar to staff. The research by Marcella and Kelley (2015) identified the need for education and for managing emotional attachment and detachment in staff. This concept is further supported in the literature that surrounds the importance and the known imperative in educating staff in aspects of palliative care (Abbey et al., 2006; Agar et al., 2012; Hasson et al., 2008). The role of the RN in leading education and secondly in the support and staff presence in the grieving timeframe cannot be underestimated.

The ability to conduct and provide an ongoing education program to staff in the 'in-house' variety is challenging in the respect of knowing the level and cognitive ability of participants, and in the establishment of suitable training materials to use (Cummings et al., 2014; Williams, et al., 2011). RN staff require the clinical leadership skills and communication skill in public speaking to successfully provide education with groups of individuals. Inherent with the competency standards for an RN (NMBA, 2016b) is the ability to provide education and mentorship to others in the health care team. Developing further from this notion is the need to recognise and develop RN clinical leaders in aged care in this space.

Irrespective of the leadership style in a residential care facility, what is known is that staff require training, mentorship and guidance to achieve success in an organisational ideal leadership direction (Cummings et al., 2014; Jeon, Glasgow, et al., 2010). The literature demonstrates that there are areas of deficiency in relation to education and training in clinical leadership and professional practice particularly in the field of aged care nursing (Dwyer, 2011; Stanley, 2006; Venturato, 2007). Through education, research and the use of evidence to guide practice, staff can become more enabled in their roles to assert greater leadership capacity within their scope of practice (Moloney et al., 2016; Pearson et al., 2007; Williams et al., 2011). Increasing leadership capacity and confidence provides a key role in assisting in staff recruitment and retention models in the sector (Duffield et al., 2011; Hayes et al., 2012; Venturato et al., 2007). Understanding the leadership role of the RN in the residential aged care setting and the requirements of the role as articulated by staff could add to the staff education role of the RN.

2.11.4 Registered Nurse Self Education

As the nursing profession faces a shortage of nursing leaders research conducted by the team led by Cummings et al. (2008), Cummings et al. (2010), and Germain and Cummings (2010) identified the need for a greater impetus in implementing strategies to ensure effective leadership is valued particularly in the clinical area of care in nursing practice. The outcomes from this research identifying key concepts in collaborative relationships in practice and the need for RNs to enhance their ability and motivation to perform (Cummings et al., 2010). The development of staff and future leaders through mentorship, education and supportive work environments plays an integral role in the future of RN led leadership in the residential aged care setting. Dearmon et al. (2015) and Chreim, et al. (2010) identify a strategy for engaging all staff as change agents with the suggestion to embed lifelong learning through mentoring in practice. It is through this research that a focus is collaborated on not just fixing problems but engaging and working with staff to facilitate the required changes.

Whilst mentoring is one strategy the Aged Care Workforce Report (2013) identified, further initiatives to encourage UHCWs to undertake further education and training are noted (King et al., 2013). As the level and complexity of care increases for residents in aged care facilities, the need for specialised aged care qualifications will also increase. The need for the ability to understand, enact and reflect on practice is key in the role of the RN. The implementation of evidence-based practice is a key component of assessing and provision of care requirements in the residential aged care setting and this requirement escalates as chronicity and aging increases (Moloney et al., 2016; Pearson et al., 2007; Williams et al., 2011).

Inherent in the role of the RN is the need to embed education and evaluate needs and priorities in the setting. The leadership role is vast and the care residents require is complex. Currently the proportion of clinical care staff and RNs in the aged care workforce undertaking education in Australia is low at a noted 13 per cent (King et al., 2013, p. 20). The areas of study are identified in Table 3 and are reflective of those studying in aged care, health and management. The data clearly demonstrates the need for the promotion of educational opportunities within the

sector with an identified 87 percent of RNs not participating in any ongoing educational opportunities.

Table 3: Field of current study of the residential direct care workforce, by occupation: 2012

Field of study	RN (RN)	EEN (EN)	Personal Care Assistant (PCA)	Allied Health Assistant (AHA)	All occupations
Not currently studying	87.0	81.1	75.1	78.6	77.9
Currently studying	13.0	18.9	24.9	21.4	22.1
Of those studying					
Aged Care	8.5	1.3	27.7	9.6	22.2
Health	40.3	71.2	56.6	59.0	56.8
Management	31.8	19.0	5.2	13.3	9.4
Other	19.4	8.5	10.5	18.1	11.6
Total	100	100	100	100	100

Source: King et al., 2013, p. 20

2.12 CAREER PATHWAYS

The Productivity Commission report (2011a) discusses the need for the industry to set a sustainable career path in the aged care sector. This includes 'wages, improving access to high quality education and training, developing well-articulated career paths, improved management, extending scopes of practice, reducing the regulatory burden, and the better use of technology' (Productivity Commission, 2011a, p. XLV). The Productivity Commission Report Recommendations (Productivity Commission, 2011a, p. LXXV) include educational parameters such as the promotion of skill development, vocational training, tertiary undergraduate and postgraduate education opportunities and leadership and management training as key drivers to success with staffing requirements and skill development in the residential aged care setting. The Commission Report (2011b) recognises the need for specialist nursing positions with the increasing dementia and palliative care requirements of older persons. In a study investigating the capacity of palliative care approaches in the residential aged care setting for residents with dementia it was identified that there were challenges and barriers to this care as the structure of the residential aged care setting places additional burdens on staff (Chenoweth et al., 2010; Choi et al., 2011; Johnson et al., 2009; Walmsley & McCormack, 2015). Key findings in a number of studies identified a communication deficit between staff and residents and the resulting need for education, skill

development, networking and the implementation of best practice palliative care initiatives (Agar et al., 2012; Begley, 2009; Hasson et al., 2008; Johnson et al., 2009).

Further support is noted in a systematic review by Cummings et al. (2010) where emphasis on developing quality practice environments to rebuild the nursing workforce is reviewed. This rebuild includes core elements of work conditions, staff behaviour and relationships, current and future education requirements and the structure and process of leadership (Cummings et al., 2010). It is this work that is critical given the growth needed in the health services workforce to meet the demand of aged care services in the coming years and the particular relevance to the future leadership role of the RN in the sector (Bellis, 2010; Goss, 2008; Mason, 2013; Productivity Commission, 2011b).

2.13 NURSING GOVERNANCE IN AUSTRALIA

The scope of practice governing nursing in Australia is clearly documented (National Law, 2016; NMBA, 2007). The legislative governance is naturally concerned with the operational and governance determinations of care provision (Aged Care Act, 1997). Operationalising this in the legislative scope forms a key part of the leadership role of the RN. It is in this realm that care delivery is more than just knowing, and is also represented through a skills base linked inherently with the incorporation of an emotional and spiritual side of care (Barbosa et al., 2015; Bellis, 2010; Brownie & Horstmanshof, 2012; Crilly et al., 2012; Sitzman, 2007;Williams et al., 2011). Nursing is very much about the practical side, meeting care deliverables and legislative requirements. It is explicitly about the care and the caring that occurs combined with the emotional and spiritual sense (Cameron & Brownie, 2010; Donohue-Porter, 2014; Sitzman, 2007; Williams et al., 2011). The literature indicates that it is in this sense that leadership shines, that residents become secure with the care they receive and that staff feel motivated to provide the best care and are empowered to implement best practice standards (Castle & Decker, 2011; Crilly et al., 2012; Williams et al., 2011). To achieve the required clinical care outcomes each individual in the team operates within guidelines. It is this, termed the scope of practice that guides and prescribes the level and depth of care that is able to be provided by a particular practitioner. Scope of practice has been defined

in the literature as 'the activities that an individual healthcare practitioner is permitted to perform within a specific profession' (Klein, 2007, p. 155). Scope of practice refers to 'the functions that both RNs and EENs are educated for, and are competent and authorised to perform' (Klein, 2007, p. 155). Workforce shortages and economic constraints have resulted in changes to the scope of practice for the EEN particularly in the aged care setting (Jacob et al., 2013).

Working in the residential aged care sector as an RN, EEN or UHCW provides the opportunity to work with residents over sometimes lengthy timeframes (Agar et al., 2012; Hasson et al., 2008; Johnson et al., 2009). The relationships that develop and grow in this timeframe differ from colleagues working in the acute care sector where patients are admitted and discharged usually in relatively short periods of time (Shield, Tyler, Lepore, Looze, & Miller, 2014; Tuckett, Hughes, et al., 2009). Staff in residential aged care settings have the privilege of working with residents in a home-like, yet clinical environment. This entitlement gives staff the ability to gain a greater insight into family dynamics and the individual as a whole (Agar et al., 2012; Hasson et al., 2008; Honkavuo & Lindström, 2014; Johnson et al., 2009; Marcella & Kelley, 2015). This includes not only their physical world but also the psychological and spiritual world to which they belong. This sense of relationship adds further strain at the time when an individual's health declines and death occurs (Honkavuo & Lindström, 2014; Marcella & Kelley, 2015). The literature affirms that aged care staff caring for people living in residential aged care experience a connection both personally and professionally with the resident that is often developed over years of caring for them (Bellis, 2010; Marcella & Kelley, 2015; Shield et al., 2014).

It is through the RN, the EEN and predominantly the UHCWs that the day to day resident care requirements occur. Clear in the nursing literature, and the professional nursing codes of ethics and standards of professional practice are explicit requirements that emphasise the importance and integration of leadership from the role of the RN (Acree, 2006; Avolio & Bass, 1999; Dignam et al., 2012; NMBA, 2016b). However within the National Competency Standards for the RN in Australia (NMBA, 2016b) the characteristics of leadership are inherently realised rather than articulated in the practice of an RN. As a result all RNs play a role in leading in the clinical environment (Hallinger, 2003; Martin & Waring, 2013;

Salmela, Eriksson & Fagerström, 2012). This is inclusive of care planning, delivery, evaluation, referral and consultation with members of the multidisciplinary team. What is known is that it is greater than a leadership style or particular attribute and comes from the emotional and spiritual context within a person (Castle & Engberg, 2008; Clement-O'Brien, Polit, & Fitzpatrick, 2011; Duffield et al., 2011; Sitzman, 2007; Williams et al., 2011). For these reasons, leadership and care provision work closely together. The models of care that are present in the residential aged care setting provide challenges to the RN. Layout and design of the facility may restrict easy access to all clinical areas. This, coupled with the large UHCW workforce that prevails, makes RN supervision and leadership difficult at times.

2.14 WORKFORCE CHALLENGES

Determining the leadership role of the RN in a specific setting requires information surrounding the organisational barriers. In all workplaces the dynamics between individuals, the resourcing, and the financial situation are attributes that determine the working climate for staff (Schaik et al., 2014; Weller et al., 2014). As clinical leaders, the RN is a critical component to the attributes of climate and organisation (Kanter, 1977). Two qualitative studies identified in a systematic review on the experiences of RNs in aged care nursing described the experiences of the RN in this setting as a clinical leader (Dwyer, 2011; Howieson & Thiagarajah, 2011). Both papers highlighted the extent of organisational barriers that de-motivated nurses and prevented pathways for learning and continuous improvement (Dwyer, 2011; Howieson & Thiagarajah, 2011). A key concern identified in a study by Spence-Laschinger et al. (2013) was the lack of communication and collaboration amongst health care workers and the resultant increase in adverse events in the clinical setting. This links intricately with the roles of each of the members of the team, not only one individual but rather the collective of all, in how, when and what is communicated. It is in this notion that leadership plays an important role in creating positive clinical work environments that empower staff, and provide quality care to residents (Arnold & Boggs, 2013; Chen et al., 2011).

There is limited literature in relation to the kind of leadership styles and behaviours that are explicitly associated with residential aged care settings and how these influence the relationship between staff in this setting (Anderson et al, 2003;

Havig et al., 2011). The complexities are outlined, the workforce demands clear, the notions of what doesn't work identified. Through leadership driven from the frontline by the RN, the responsibility and accountability for care decisions in the residential aged care setting creates a role where burnout and fatigue occurs (Bowers et al., 2011; Chu et al., 2014). In a systematic review exploring the experiences of RNs as managers and leaders in residential aged care facilities five themes associated with the impact of leadership and management were identified in a study conducted by Dwyer (2011). These themes are: '(1) staff job satisfaction and retention; (2) successful change and positive work culture; (3) staff productivity and unit performance; (4) care quality and resident outcomes and (5) associated costs' (Dwyer, 2011, p. 390). The systematic review identified that little is known about the systems and policies required to facilitate effective leadership in the aged care sector. More importantly the literature identified that many RNs are poorly equipped with leadership skills and find themselves unprepared for the complex supervisory role they hold in aged care (Dwyer, 2011; Pearson et al., 2007). Another systematic review of issues surrounding nursing education and training in aged care (Pearson, Pallas, et al., 2006) identified that further research is needed in leadership and learning, particularly in the aged care sector.

2.14.1 Staff Motivation to Perform

Research examining leadership in the aged care sector has focused on RN productivity and what particular factors affect a nurse's ability to perform well (Germain & Cummings, 2010; Loke, 2001; Wong & Cummings, 2007). These studies have identified that RN leadership has a direct influence on autonomy, relationship building and nursing practice and the areas that influence a staff member's motivation to perform (Cummings et al., 2010; Loke, 2001; Wong & Cummings, 2007).

In any employment opportunity individuals seek to be acknowledged, supported and developed (Bishop, 2013; Egan, Yang, & Bartlett, 2004; Tuckett, Hughes, et al., 2009). This sense of purpose provides a key ingredient in what makes individuals, or even groups of individuals, care, or be motivated to care. It is this ingredient that provides key impetus to the outcomes of care, that is, the quality of care provided to residents and the overarching resident outcomes that eventuate.

Motivating staff and engaging staff in the workplace from the inclusion and engagement in decision making, the inclusion in quality activity ownership, and the inclusion in work based initiatives, provides an individual with a sense of purpose (Germain & Cummings, 2010; Shield et al., 2014). This inclusion and engagement is one aspect that creates an environment for staff to want to be at work, to want to do well and to want to promote the workplace. With the demand that is placed on the RN in the residential aged care setting, that ability to deliver a workplace conducive to the engagement and inclusion of staff is often difficult (Salanova et al., 2011; Schneider & Macey, 2007). This, coupled with a predominance in UHCW staff, and a limited pool of peers to consult and communicate with, assigns the RN to a potential role of vulnerability and isolation (Huai-Ting et al., 2008; Shield & Enderby, 2006). These factors contribute to a decreased sense of self and a decreased sense of power within the decision making process (Bergman et al., 2012; Supovitz & Tognatta, 2013). For this reason aspects that enhance job satisfaction and the resultant retention of staff in the setting are key in the organisation and leadership structure.

2.14.2 Employee Satisfaction and Retention

Recruitment into the residential aged care setting is not an easy task (Venturato et al., 2007). The negative connotations that drive aged care and 'aged care nursing' depict a sense of work in an environment where conditions are less, wages are less, and the profile of specialisation is low (Hodgkinson et al., 2011; Tuckett et al., 2011). Recruitment and retention of staff comes with their own complexities in the area. There is evidence in the literature to support low recruitment and early exit of nurses throughout the Australian health care industry and this is further exacerbated in the aged care sector, through the combination of demanding staffing requirements and lower pay conditions (Chenoweth et al., 2010; Huntington et al., 2011; Tuckett et al., 2011).

The Productivity Commission (Productivity Commission, 2011a, p. XXVII) identifies that there is a definitive need to review workforce shortages as the aged care workforce will only continue to expand given the growing aging population in Australia. The ongoing need for care provision that meets the health system's capacity and capability is required (Hughes, 2011; King et al., 2013). The expected

nurse shortage in the coming years will further enhance the competition for nursing staff in the recruitment market from an organisational perspective (Hughes, 2011; King et al., 2013). The effect of this shortage on the aged care sector will further increase recruitment challenges. Efforts to increase the interest in attracting RNs in caring for the older person in residential aged care settings is vital to ensure that care requirements and specialisation within dementia, palliative care, chronic disease and elder care are initiated (Duffield et al., 2011; Kleinman, 2004; Venturato et al., 2007).

Success in the retention of staff in the setting is also dependent on the work engagement shown from the employee base. Work engagement is seen by Bishop (2013, p. 942), as 'a personal and professional commitment to both the job and the organisation'. This notion of commitment is born from the desire to work with the aging population and the motivation in establishing and providing best practice care standards to this group of individuals (Bishop, 2013). Engagement is not a simple entity. The literature describes three layers to the overall concept of engagement that includes vigour, dedication and absorption (Bishop, 2013). These layers collectively utilised from the leadership role can encourage, lead, connect and influence the practice of caring within a residential aged care setting (Bishop, 2013). However, in isolation, these concepts are difficult to maintain, complex to uphold and physically draining in an individual's solitary focus.

The linkage with teams, the motivator, and the enhancer is what is required with the essence of the follower to enact and respond to the vigour and vitality displayed. Engaged employees are physically energised, develop a sense of purpose, of understanding of both the science of knowing how to care and of the art of understanding the spiritual and emotional context (Bishop, 2013; Lynch & Verner, 2013). Nursing leadership through the role of the RN in this sense creates organisational structures that empower staff to deliver quality care to residents whilst balancing the expectations of work life and organisational goals (Spence-Laschinger, Gilbert, Smith & Leslie, 2010; Spence-Laschinger et al., 2013).

2.15 IMPLICATIONS FROM THE LITERATURE

The complexity of issues surrounding RN leadership in residential aged care settings contains many layers. Understanding the associated quandaries in firstly defining the term ‘old’, begins a cycle of negative synonyms relating to loss of function or ability in a person as they age. Historically, the literature uncovers the myriad of industry related concerns inclusive of increased resident acuity, increased palliative care and dementia-specific resident needs and care requirements, greater regulatory demand and a corresponding increase in government expenditure. Coupled with the complexity of concerns arising are the high proportion of UHCW workforce in aged care facilities and the lack of government agendas to increase the interest and specialisation of the aged care industry to RNs.

Understanding further the ability of the RN to practice and engage as part of the professional standards of the nurse, and to effectively lead members of the clinical care team in this engagement, is complex. It is evident in the literature that barriers to successful leadership have been identified and include work environment stressors, concerns surrounding future recruitment and retention, staff motivation and time for leading. A number of systematic reviews and literature reviews have investigated the impact of leadership and management on staff experience in the healthcare sector.

The literature indicates the concept of clinical leadership in the clinical area as a complex being, making conceptual frameworks for use in the clinical domain convoluted and difficult to comprehend. The literature has exposed the essence of understanding further the complexity involved in identifying what leadership is in the aged care setting. The role of the RN in the residential aged care setting is somewhat outlined in alignment more generically with health leadership roles, however, the leadership role specifically of the RN is not defined in the literature. The concept of clinical leadership and the characteristics presented provide a presumption of the leadership role of the RN. The implications for practice of the leadership role of the RN in the residential aged care setting remain with questions to answer.

There is a plethora of information surrounding the attributes and characteristics associated with the leadership theories and definitions historically to contemporary practice settings. Extending from this, the complexity of understanding specifically the RN leadership role from the experience of clinical care staff in the specific context of residential aged care settings is not comprehensively available the literature. The literature highlights the need for the RN to educate, guide and support UHCWs; the absence of education engagement is noted and the need for more proactive approaches is provided. What specifically this leadership entails requires further investigation.

The negativity related to working in, and caring for individuals in a residential aged care setting, matched with government pressures and fiscal resourcing, has compounded the ability to recruit and retain qualified RNs in this area. Further, the sector is burdened with various workforce challenges and is now in a precarious situation with a population boom in our older Australian population. These concepts linked with an aged care system caught in the abyss of flux as it moves from the medical domination of care to more resident centred approaches to care delivery at a time of ongoing change and reform. It is in this time of change that policy development and the resultant RN leadership must be inclusive of parameters that enhance an individual's well-being whilst balancing the scale with the provision of quality care; lifestyle based choice and appropriate care planning, and care implementation and evaluation from the leadership role of the RN. The complexities identified in the literature are presumed to have an impact on the work conducted by the RN.

The literature has provided an overview of the work related pressures of leading in the residential aged care sector, however the nature of the RN leadership role is not defined or captured. The implication for an RN where a defined leadership role is not clear or articulated further accompanies the organisational behaviours and undertakings of the RN in the designated leadership role. What appears is a leadership by position of being the only RN on shift, or a leadership by role rather than by authority or desire as part of a career progression pathway. It could be argued that the complexity and challenges faced in the sector are further exacerbated without an understanding of the leadership role of the RN by the RN themselves. This extends to the appropriate recruitment of RN staff and the resultant

retention of staff in the sector. The literature ascribes to ongoing concern in these areas.

The complexity of RN leadership in its individual state of a person is one factor, one principal position, however it takes a whole team to coordinate and deliver the holistic care required and the literature affirms this. The informal leader and the power exerted can be the impetus for change, the positive or negative force with care and care coordination and in leading the team. The complexity of leadership theories and the ever evolving nature of RN leadership are suggestive from the synopsis of the literature of the complexities in residential aged care settings. These are suggestive areas of thought and require the research to determine the leadership role of the RN in the first instance. The understanding of this theoretical concept is utilised in the development and orchestration of models of leadership practice for RNs in the aged care settings and also for organisational direction, guidance and support for the RN role.

The factors and points of discussion in this literature review form a background to understanding the leadership role of RNs, the nature of leadership practices in the challenging health context of the residential aged care setting and the leadership theories and characteristics that are displayed. This is an important feature given the industry related factors derived from the literature and the need for nursing leadership from the RN to be engaged and active as change agent, visionary and advocate for both the resident and the nursing profession. The importance of RN leadership to the provision of care to the aged is unquestionable. This core of care, the central focus of nursing from the RN particularly in the guidance and coordination of care with and through the teams associated with the residential aged care setting. Leadership at not only the formal level, but also informally through the role of the RN is greater than a function of management and something that empowers staff in the role they hold and in the work they engage. Knowing and understanding further the leadership construct of the RN is important and the impact of organisational features, behaviours and work patterns on this role requires understanding and linking to the RN role.

Staff empowerment and inclusivity are points of discussion in the framework offered by Kanter (1977) and are transferable and applicable to the leadership role of the RN. The nursing literature in this area is strong with a key focus on team work and team building as a means of inclusivity and empowerment (Arnold & Boggs, 2013; Asencio et al., 2012; Chen et al., 2011; Chenoweth et al., 2010; Donohue-Porter, 2014; Huntington et al., 2011; Jeon, 2014; Lanzoni & Meirelles, 2011; Scott-Cawiezell et al., 2004; Tuckett et al., 2011). Organisational leadership and the effect this has on an individual in a leadership role are explored through the power influences that present.

These areas of practice and leadership that have been discussed from the perspective of the literature are further explored through the works of Rosabeth Kanter (1977) in Chapter 3. It is in this chapter that the links and understanding of the structure of organisations is presented. It is the structure of organisations that provides the environment and the climate for the act of RN leadership in the residential aged care setting to occur. This structure of organisations provides the context linking these characteristics of the leadership role of the RN with Kanter's structure of organisations and the behaviours exhibited.

Chapter 3: The Structure of Organisations

3.1 INTRODUCTION

In the residential aged care sector the RN seeks to care and gains satisfaction in providing quality care to residents irrespective of the organisational pressures on them (Spence-Laschinger et al., 2010; Spence-Laschinger et al., 2013; Venturato et al., 2007). The organisational pressures when not managed detract from the satisfaction desired and can lead to staff dissatisfaction, reduced motivation and staff resignations (Bamford et al., 2013; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006). The notion of leadership, the role of the RN, and the legislative and historical underpinnings of the aged care sector in Australia have been explored in Chapter 2.

Chapter three builds on the literature review and presents the structure of organisations (section 3.2) and the influences that these present on the leadership role of the RN and the staff in the residential aged care clinical team. These influences are discussed in relation to Kanter's (1977) theory of organisational behaviour where the structure of opportunity (section 3.3) and the structure of power (section 3.4) present. Section 3.5 discusses organisational leadership as it relates to Kanter's theory (1977). This context of leadership is discussed in section 3.6 through leading teams and leadership at the frontline (section 3.6.1). This introduction on leadership in teams is further presented through Kanter's theory of leaders and followers in section 3.7. Section 3.8 outlines Kanter's (1977) change and organisational theory with discussions progressing to team belongingness (section 3.9) and staff empowerment (section 3.10). Section 3.11 outlines the implications of organisational theory on the leadership role in organisations, in this respect the RN in the residential aged care setting.

Kanter's (1977) ethnographic study of work environments in large American corporations led to the evolution of Kanter's theory of organisational behaviour. This chapter explores the organisational context and the influencing factors on the leadership role of the RN through the conceptual framework viewed through the works of Rosabeth Kanter (1977) and the respective theory of organisational

behaviour. The chapter commences with a discussion on organisational leadership and the influences from an organisational context on teamwork and the frontline delivery of services. The framework outlined by Kanter (1977) represents a number of areas relevant to staff and the interactions that occur in organisations. These are inclusive of the structure of power and opportunity, the need for both a leader and follower in an organisation and the effect change and organisational culture has on the role of leaders in organisations and in this particular research, the residential aged care setting.

3.2 THE STRUCTURE OF ORGANISATIONS

It is through Kanter's (1977) research that the development and further refinement of six (6) key structural organisational conditions were identified that are conducive to workplace empowerment and leadership. These conditions are; access to information, support, resources, learning opportunities, and formal and informal power sources. Since Kanter's original research in 1977, a vast degree of change has occurred in organisations, however the concepts and discussions of Kanter's theory of organisational structure and empowerment remain applicable to the work conducted in many industries including that of the residential aged care setting today (Kanter, 1977; McManus, 2013).

According to Kanter (1977), a subordinate's ability to access empowerment structures in an organisation is often dependent upon their supervisor's ability to access empowerment themselves. That is not to say that staff are not willing and able to assert change, but rather a force minimises or stops the progression of this change. It is the efforts of residential aged care staff with the capacity, skills and legitimacy to drive changes in the aged care setting, as they are the individuals aware of the situations and dilemmas in the setting that need to change. It is the RN that leads care in the residential aged care setting, however they are often the individual caught between management and care provision (Anderson et al., 2003; Crilly et al., 2012; Scott-Cawiezell et al., 2004).

RNs in the residential aged care setting appear marginalised in their decision making capacity, and are restricted in role flexibility and visibility (Bellis, 2010; Yun-Hee, 2014). Focus on care provision and compliance with aged care standards

and accreditation documentation appear at the fore of care and the work conducted (Bellis, 2010). Further to this in a study in the United Kingdom Martin and Learmonth (2012) identified in their findings that the durability of institutional and structural forces often limit the extent to which leadership roles can be enacted in an organisation. Kanter (1977) theorised that it is workplace characteristics that are influential to employees' attitudes and behaviours rather than the personal characteristics that exist (Faulkner, 2008; Kanter, 1977). There is then, an increasing expectation that, with the right support and with some structural changes, residential aged care workers including the RN can exercise positive leadership roles. Kanter's (1977) theory of organisational behaviour is relevant to the RN in the residential aged care setting and the leadership role demonstrated and enacted from within the position. In any work setting there are influences and challenges. Knowing these nuances and the impact organisationally is offered from a theoretical perspective from Kanter (1977).

The complexity in defining leadership conjures thoughts on what is actually contained within a collective definition and it is at this stage that the notion of power, influence, followership, personality, charisma, goals, warmth and discretion come to mind (Bamford et al., 2013; Bowers et al., 2011; Castle & Decker, 2011; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006). Kanter's (1977) theory of organisational behaviour elaborates on these areas in discussions surrounding organisational structure. Kanter (1977) describes three organisational structures that guide work behaviours in organisations. The three structures are power, opportunity and proportions (Kanter, 1981, 2010).

3.2.1 The Structure of Power

Power within a person '...is the force radiating from a person that obtains the respect of others without the authority of a position of power' (Parse, 2004, p. 101). It is not about position or what authority one holds from within a particular role but rather appears to be based on respect, knowledge, skill, compassion and the communication with others in the team. Power is defined as '…the ability to mobilise resources to get things done' (Kanter, 1977, p. 166). Power in positions is what is commonly seen and discussed in the literature where a manager, RN or executive leads a team of workers (Blaney, 2012; Bogue, Joseph, & Sieloff, 2009;

Briggs, Smyth, & Anderson, 2012). This formal power forms part of a position, is associated with positions in an organisation that have '...high visibility and are essential to the organisation's function and decision making capacity' (Wagner, Cummings, Olson & Anderson, 2010, p. 449). In the aged care setting the RN has charge of the team however the complex web of interactions enable different power relations to emerge. When leader responsibilities are aligned with existing power relations employees are able to manage to lead (Anderson & Reuben, 1998; MacPhee et al., 2012; Martin & Waring, 2013; Supovitz & Tognatta 2013).

Correspondingly, leadership theories in practice delineate various forms of leadership and how they are enacted in organisations often from the boardroom to the frontline of care (Dearmon et al., 2015; Hartley & Benington, 2010). With the domain of nursing leadership in residential aged care settings, recent studies have identified the importance of 'distributed' leadership approaches for achieving organisational change (Chu et al., 2014; Dearmon et al., 2015; Grant & Crutchfield, 2008; Howieson, 2012; Williams, 2012). The distributed approach to leadership is interesting as this view relates to RNs in practice. It is the RN that it is often working with little authority in care coordination and who are the most powerful to the resident and in the guidance to others in their charge. It is these RNs that can change and lead through collaboration. It is an interesting concept and gentle reminder for those with formal power just how much they rely on the numerous stakeholders they work with for any real power they are perceived to have (Chreim et al., 2010; Dearmon et al., 2015).

According to Kanter's (1977) theory, power is derived from formal and informal sources. Formal power is derived from positions that are relevant to key organisational goals (Faulkner, 2008; Wagner et al., 2010). Informal power is derived from the quality of alliances and relationships with people in the organisation (Spence-Laschinger et al., 2010; Wagner et al., 2010). It is through these alliances that informal sources of power enable individuals to get the co-operation and collaboration of the team they work with to achieve the work required.

Alternatively, '...lack of power creates staff who are more concerned about guarding their territories than about collaborating with others to benefit the organisation' (Kanter, 1982, p. 155). As a result no discussion on leadership in the

aged care sector would be complete without also discussing the notion of follower. The leading-following act requires both lead and partner to rhythmically and sequentially focus and decide where together they stand.

The power of the RN is often underestimated by the RN themselves. It is often the informal power of the individual within the residential aged care setting that influences the care and decisions surrounding care in this context (Chenoweth et al., 2010; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006; Yun-Hee et al., 2013). Kanter (1977) describes the two specific empowerment structures within organisations as the structure of opportunity and further as the structure of power. It is these two different sources of power that create the culture, set the scene and harmony within a workplace, or one that creates conflict and chaos, and interferes in a negative manner with the leadership and consequently the care provided to residents (Caspar & O'Rourke, 2008; Kanter, 1977, 1981, 1982, 2010, 2011; Spence-Laschinger et al., 2010).

3.2.2 The Structure of Opportunity

The ability of the RN to advance career standing in the residential aged care setting is somewhat restricted (King et al., 2013). Kanter's (1977) theory of organisational behaviour discusses the concept of opportunity with particular respect to an individual's position and the conditions that provide staff with opportunities to advance within the organisation, and to advance their knowledge and skills in the work setting (Kanter, 1977, 1981, 2010). It is through opportunity that staff are able to increase their knowledge and skills, and have an opportunity for growth and advancement in the setting. It is through these areas that staff are able to find satisfaction in the work they do (Spence-Laschinger et al., 2010; Spence-Laschinger et al., 2013; Venturato et al., 2007). As Kanter (1977) discusses, the structure of opportunity is inexplicitly linked to conditions in a position and the ability or chance to advance in the organisation. It also allows for further development of suitable skills and knowledge for both a current employment position and also for future advancement.

Within the residential aged care setting the notions of advancement are not part of the current agenda relating to RNs in the sector (Productivity Commission, 2011a). In reality the literature does not articulate the area of aged care nursing as a

subspecialty (Cameron & Brownie, 2010; Dwyer, 2011), but rather an area of nursing practice viewed where less skill may be required (Chenoweth et al., 2010; Productivity Commission, 2011a). Structural empowerment, according to Kanter (1977), is more important to employee performance than personal attributes alone. Employees naturally look for areas of advancement, seek information to improve their role and require the necessary support and resources to achieve this. The type of empowerment an individual may seek differs from person to person (Kanter 1977). In the residential aged care setting role advancement within the realms of the RN is limited (Goss, 2008; King et al., 2013). For the RN advancement in the residential aged care setting entails specialist roles in funding, quality or management (Howieson & Thiagarajah, 2011; Jeon, 2014; Jeon, Glasgow et al., 2010; Jeon, Merlyn et al., 2010). Opportunities to advance within the clinical domain are restrictive and also further remove the RN from the bedside leaving the focus of care, and entering further into the domain of compliance and regulation (Angus & Nay, 2003; Bellis, 2010; Hughes, 2011).

The theory of organisational behaviour by Kanter (1977) secondly discusses the notion of high and low opportunity positions. High opportunity roles are described as those that take a proactive approach to problem solving and which actively participate in workplace change and innovation. Low opportunity positions tend to limit work ambitions, are less dedicated to the organisation and are guarded to workplace change (Kanter, 2011). With an extensive research background with large organisations, Kanter (1977, 1981, 1982, 2010), maintains that opportunity is a key influence on employee work satisfaction and productivity.

Working in the residential aged care setting as a RN is a demanding role and one that is at the fore in relation to resident assessment and care evaluation. It is also this role that provides the pivotal link between resident and staff, and staff and management (Howieson & Thiagarajah, 2011; Jeon, 2014; Jeon, Glasgow et al., 2010; Jeon, Merlyn et al., 2010; Stanley, 2014). For this reason the role innately is seen as one of authority by those working in the facility. However for the RN, the role is often seen as the gatekeeper, the problem solver, yet the one person unable to affect the changes they see are needed (Baernholdt & Cottingham, 2011; Bender et al., 2013; Davidson & Elliott, 2006; Enterkin et al., 2013). The influence and power of an organisation can affect an individual’s psyche to set a mood, spark enthusiasm,

make peace or give a space for reflection that cannot be underestimated. Caspar and O'Rourke (2008) identified that support in the form of access to educational opportunities and recognition for a job well done is of greatest significance to the UHCW in the residential aged care setting.

3.2.3 The Structure of Proportions

Proportions can be defined as the numbers of socially and culturally different people in a group (Kanter, 1977). The definition alone does not articulate into the transition in practice in the residential aged care setting without further examination. The structure of proportions is critical in shaping interactions and dynamics in a workplace. In defining the interactions and dynamics involving care staff engaged in the residential aged care setting what is known is there are high proportions of UHCWs, smaller numbers of EENs and RNs. This data was defined in the literature review in Table 2, Section 2.11. The representation in the residential aged care setting can be identified as a 'skewed group' (Kanter, 1977; 2011). This skewed group visualised in the known low numbers of RNs in the setting proportionally to the UCHWs that are present. In understanding the structure of proportions three perceptual phenomena appear. These are visibility, polarisation and assimilation (Kanter, 1977; 2011). Visibility generates performance pressures, for the RN the restricted visibility can create perceptions in relation to being available or not being available to UHCWs in the setting. Polarisation leads to UHCWs and EENs polarising or dominating their group boundaries in relation to care and care decision making practices and assimilation leads to the RN having a sense of entrapment in the system or workforce configuration in the residential aged care setting. To work in organisations staff need to know and understand their role and the resulting obligations. Gaining a familiarity with the structure of proportions through education is important.

It is organisations with work environments and staff that can access education, training and support that have the potential to thrive (Baines et al., 2014; Duffield et al., 2014; Germain & Cummings, 2010; King et al., 2013; Pearson et al., 2007). It is these organisations that provide and see opportunity and provide the resources that allow staff to practice and lead within the organisation. It is these organisations that are successful in maintaining positive work environments (Caspar & O'Rourke, 2008;

Spence-Laschinger et al., 2010; Upenieks, 2003). The approach sits well within the realms of residential aged care. Residential aged care settings are in a state of constant change and the need for ongoing alignment into the future to meet the growing aging population coupled with the chronicity of care is high (Anderson et al., 2003; Angus & Nay, 2003; Hurley & Hutchinson, 2013; King et al., 2013).

3.3 ORGANISATIONAL LEADERSHIP

Leadership in the aged care sector is seen as a skill often within a particular group of staff with management responsibility (Dwyer, 2011; Taunton et al., 1989). However many organisations are now recognising that leaders are present in all domains of the organisation and not just at the apex (Hartley & Benington, 2010; Mortlock, 2011). Australian health care initiatives with the LEADS project articulates a leadership framework within health and calls upon managers, clinicians and even patients to be 'leaders', exemplifying good practice and influencing peers in order to achieve change (Dickson & Tholl, 2014). However in the aged care setting practical problems are faced by those exercising leadership where policy imperatives, fiscal concerns, bureaucratic structures, and professional divisions in labour may interfere with the ability of RNs to lead a team across boundaries and within hierarchies (Bellis, 2010; Castle & Decker, 2011; Tuckett, Parker, et al., 2009). Bleich (2014, p. 7) recognises that nursing has at times been under functioning for a variety of reasons, and that '... as nurses they use their intellectual capacity silently'.

Understanding how an organisation works is one of the pieces of the puzzle that helps staff in gaining an understanding of the organisational demand and being able to work within the strategic and business approaches desired. Learning and understanding more about organisational structure and the components involved, provides insight and understanding to provide leadership principles that match the work desired, the team dynamics, and the residents being cared for. It is these aspects that shape a leader's effectiveness within their role (Kanter, 1977; Upenieks, 2003).

3.4 LEADING TEAMS

Distinctively how a nursing team is led is a derivative of both the leader and the work environment (Hallinger, 2003; Martin & Waring, 2013; Salmela et al., 2012; Williams, 2011). The literature is dense with discussions surrounding the ability to achieve success in leading teams and requires firstly that leaders must be understood, empowered and have the autonomy and authority to practice (Bogue et al., 2009; Brennan, Cass, Himmelweit, & Szebehely, 2012; Trus, Razbadauskas, Doran, & Suominen, 2012). Teams play a critical role in how they communicate, motivate and work together to provide care (Miers & Pollard, 2009; Perrin et al., 2015; Weller et al., 2014). The RN may lead the whole team as a single entity, however care is often seen to be led by different individuals, at differing times, to achieve components of an overall desired outcome or shared vision. The role of the leader is not only that of problem solver of clinical situations, but also as a coordinator, mentor and educator in the residential aged care setting. Often the result of the situation at hand is within the scope of relations in which outcomes occur as a result of a combined action, created by more than one member, an action between all the participants involved (Bolden, 2011; Bush, 2013; HWA, 2012; Marles et al., 2015; Stanley, 2014; Swanwick & McKimm, 2011).

The RN holds the accountability, knowledge and ability to make decisions that guide care and lead the team to quality outcomes for residents (AHPRA, 2015; Moloney et al., 2016; NMBA, 2007, 2016b, 2016c). The traditional hierarchical medical model that dominates the residential aged care sector ensures that staff with the highest education, salary, and formal position, often remain the furthest from direct contact with residents (Bishop, 2013; Hartley & Benington, 2010). Conversely, this asserts that those with the least resident contact have the most control in determining care decisions (Caspar & O'Rourke, 2008; Faulkner, 2008). UHCWs in this sector provide the majority of all resident care, yet receive the lowest wages and attain minimal education and training standards (Baines et al., 2014; Caspar & O'Rourke, 2008). It is a situation where the worker has considerable responsibility yet lacks the authority, education, or autonomy in the process. The literature is succinct in the identification of what UHCWs want from within their role, including the need to be respected, recognised and rewarded for high care

standards, and to be included in the care planning and decision making process (Munir, Nielsen, Garde, Albertsen, & Carneiro, 2012; Pearson et al., 2007).

Teams within a residential aged care setting are more than the care team present every shift. The interdisciplinary team that works in, and for, the resident in ancillary needs, physiotherapy, pharmaceutical and medical requirements adds further care and decision making capacity in the setting. This interdisciplinary component contributes additional value to the quality of care, and yet requires the RN to enable the communication of these requirements, provide the assurance that they occur and to evaluate their success or not and report this back to the relevant team member (Bajnok et al., 2012; Whyte, 2007). It is the RN and their capacity in the system that provides the leadership to the team, albeit the culture, the organisation, the systems, and processes (Avolio et al., 2009; Dwyer, 2011; Kean & Haycock-Stuart, 2011; Kean et al., 2011).

Staffing within the teams in the residential aged care setting precludes many innovative and new ways (Hall, 2005; Weller et al., 2014). In the residential aged care setting the staffing mechanisms are more often than not coordinated through a direct resident to staff allocation process (Hodgkinson et al., 2011; King et al., 2013). That is, for each cohort of residents a number of UHCWs will be allocated. A team leader is identified, namely an EEN or a direct report to an RN. The literature comprehensively discusses the accountability and reporting responsibility of the RN working in the residential aged care setting as a whole (Pearson, Pallas, et al., 2006; Pearson, Schultz, et al., 2006; Tuckett et al., 2011; Tuckett, Hughes, et al., 2009).

The apparent discord appears in the staffing models in use and the inability to practice within the primary care model idealised for the setting (Forbes-Thompson et al., 2006; Hodgkinson et al., 2011). The resident allocation model although effective in achieving a staff to resident ratio adds further to the complexity of care and the employment of large numbers of UHCWs (Caspar & O'Rourke, 2008; Hughes, 2011; King et al., 2013). Irrespective of the model in use, quantitative data indicates that with increasing numbers of residents, increased chronic health needs and the rising numbers in an aging population there is a need for greater staffing required in the sector (King et al., 2013; Tuckett, Parker, et al., 2009; Venturato & Drew, 2010).

Workforce estimates in Australia of particular relevance to the residential aged care sector, are intriguing. These statistics demonstrate the scope of aged care services comprised 3.1 percent of the Australian workforce in 2014 (ABS, 2014). This workforce consists predominantly of women with an average age of 55+ for 27.2 percent of the direct care workforce (ABS, 2014). This figure is considerably higher than in the overall workforce that identifies 17.2 percent of workers over 55 years of age (ABS, 2014). With these identified trends noted in the models utilised in the aged care sector's recruitment of staff, due consideration is required in developing frameworks surrounding the models of care, leadership and career strategies needed to entice and engage staff to work in the residential aged care setting. The discussion in relation to the role of both the RN and EEN indicates that both roles play a lead, in some perspective, within the team (Jacob et al., 2013; King et al., 2013). Each of these roles also has minimum education requirements and national registration accountabilities legislatively bound to each individual's practice. However, discussions relating to scope of practice and the UHCW are limited with no documented minimum standard of education and no registration authority to monitor practice or care standards (Pennington et al., 2003).

Pearson, Schultz, et al. (2006) and Venturato and Drew (2010) discuss that leadership enacted in the scope of care provision in a residential aged care setting can determine the level and scope of practice that is required of each individual in a team. Organisationally, settings require a balance of staff to ensure that each component of care and care coordination can be succinctly met to achieve positive resident outcomes. The current staffing arrangements in residential care settings see the UHCW as the largest component of the workforce, with smaller distinct numbers of both EENs and RNs (Duffield et al., 2014; Hughes, 2011). The ability of the team to function according to the prescribed scope of practice for both the RN and EEN entails an understanding of the legislative requirements and the ability to enact these in practice. The complexities of this in the context of supervisory roles in the residential aged care setting that require coordinating a large unskilled workforce creates challenges to the leadership roles (Duffield et al., 2014; Grealish et al., 2010; Havig et al., 2011). Importantly, the communication in and through each of the staffing cohorts is critical to the provision of holistic care to residents. It is the

balance within the realm of the leadership that is driven from the role of the RN that is important.

3.4.1 Leadership at the Frontline

Kanter's theory of organisational behaviour posits that the central aspects of a position, being the organisation's environment and culture, shape a leader's effectiveness in their role (Upenieks, 2003). As an RN in the residential aged care setting they are thrust into a position of authority as a formal requirement of the role. This entails imperatives with decision making, communication with staff, managers, and families, along with the ability to assess situations, and resolve conflict and care decisions (Bamford et al., 2013; Josefsson & Hansson, 2011). All this is achieved whilst being able to openly, yet diplomatically, convey these imperatives to the people concerned. The complexities involved in the position are great and without the team they work with, much would not be achieved.

The undergraduate educational preparation of RNs in Australia offers only fundamental knowledge of leadership in health care settings. However, it offers no formal preparation with regard to leading teams and the complexities of this role in the workplace outside of a supervised practice context (Hendricks, Cope, & Harris, 2010). The reality of the complexities of the role and the experience required to manage a team within residential aged care settings is learnt and practiced in the postgraduate area. It is through the practice of leading teams and the mentorship from colleagues that an RN further articulates the skills and decision making confidence to bridge the divide between theory and practice.

Relationships form a key factor in the development of inter-professional decision making required by the RN. In a meta-analysis of the literature on leadership development Galuska (2012), found the relationship factor to be important with the nursing manager, with colleagues, and with mentors who guide growth and competence in decision making. The RN is dependent on the team they work within the aged care setting to ensure that all parameters of care and communication have occurred (Perrin et al., 2015).

Understanding the theory offered by Kanter (1981) and its applicability in residential aged care settings assists in providing a foundation for the development of leaders in the sector and in understanding the work environment. Collegiality is vital to this concept, as is the practice of leadership that fosters an employee's sense of respect and trust in a team. Leaders who are able to demonstrate behaviours such as competence and positive power relations are more likely to engage with the aged care team and find reciprocity of feelings of power and respect from, and within their team members (Bishop, 2013; Egan et al., 2004; Faulkner, 2008; Tuckett, Hughes, et al., 2009). Leaders in residential aged care who are able to demonstrate positive behaviours are known to influence the decisions of colleagues in practice (Bishop, 2013; Egan et al., 2004; Faulkner, 2008; Swearingen, 2004).

3.5 LEADERS AND FOLLOWERS

Opportunities for leading arise in many and varied situations in the provision of nursing care. A good leader is someone who values and respects the complex communication and decision making dyad in the aged care setting (Donohue-Porter, 2014). A follower is likely to see good in a leader if a fit is recognised with the ideals and expectations of the leader (Hamstra et al., 2014; Kean et al., 2011). This fit establishing that an effective leader has motivated and engaged followers that will focus strongly on the completion of tasks delegated (Hamstra et al., 2014). Research by Meindl (1995, p. 331) identified that leadership cannot and does not occur without followers. It is this essence that has leadership as a socially constructed phenomenon (Hamstra et al., 2014; Kanter, 1981; Kean et al., 2011). This socially constructed notion is one where engagement of staff in the day to day work delegated from the leadership role of the RN is important.

This role of leader and follower in the residential aged care setting identifies the relevance in the connection and responsiveness between the leader and the follower. Leading involves the ability to gather all the required information, think deeply, seek multiple perspectives, acknowledge complexity in situations, stimulate creativity and determine the focus of nursing care required (Donohue-Porter, 2014). Following ensues when the trust and engagement is enacted by staff (Hamstra et al., 2014; Kean et al., 2011; Meindl, 1995). It is asserted in the literature that the leader is someone with authority having the power and capacity to lead assertively from the

front (Dignam et al., 2012; Martin & Waring, 2013). This apparent ability to ‘do leadership’ remains to some extent in compliance in organisational structures and processes and is based on what is seen as normal practice in the particular aged care setting.

Informal power in an organisation, according to Kanter (1977), involves the selective choice of alliances in the organisation that enables employees to get the cooperation they require to achieve work goals or demands. The strength and resilience of these alliances determines the ability of an employee to mobilise what is needed to get work goals completed. A positive influence or mobiliser through informal power structures enables goals to be achieved, and in turn has a positive effect on work attitude and behaviour. This informal power also empowers the team and provides the confidence and capacity to achieve more (Kanter, 1981; Spence-Laschinger et al., 2010; Upenieks, 2003). Conversely if the outcomes are negative and staff in the residential aged care team are unable to be empowered negative feelings may develop that can impact on work performance, diminish or minimise confidence and create fractures within the care teams (Bishop, 2013; Egan et al., 2004; Faulkner, 2008; Kanter, 1981; Tuckett, Hughes, et al., 2009; Upenieks, 2003). The complexities identified in residential aged care teams can create situations where the ability of the formal leader to sometimes engage and let go occurs (Arnold & Boggs, 2013; Chen et al., 2011; Chenoweth et al., 2010; Huntington et al., 2011; Tuckett et al., 2011). This is evident in a number of papers that discuss the concept of team structure and the need to guide, provide, and lead the team (Asencio et al., 2012; Goss, 2008; Wang et al., 2014; Weller et al., 2014). The difficulties appear to be based on persona, control and the need to do it oneself. This leads to a sense of disempowerment of staff and then the reluctance of staff to become engaged and involved in activities.

In practice, a disempowering culture is one of the de-motivators of aged care staff in leading the team, particularly where decision making is ‘undone’ by the existing norms and structures of the aged care organisation (Cummings et al., 2010; Spence-Laschinger et al., 2013). This notion, commonly in nursing referred to as ‘*the way things get done around here*’ creates work teams and cultures based on doing rather than on promoting optimal nursing care. The creation of cultures in this structure potentially restricts access to resources, information, support and

opportunity, all rendering the employee powerless (Cummings et al., 2010; Martin & Waring, 2013; Spence-Laschinger et al., 2010). This undoing of practice further disempowers the aged care workforce and undermines a leader, and their potential and desire to care (Kanter, 1981, 2011; Spence-Laschinger et al., 2010). The residential aged care setting is encased in a distinct historically founded hierarchical structure, governed by strict bureaucratic legislation and auditing processes. For many decades the setting has evolved and maintained a strong function and existence within a medical model of care. The environment is in itself limiting and one that the RN leader must work in and develop relationships with a network of staff, visiting health professionals, consumers, relatives and residents to maximise job empowerment.

3.6 KANTER'S CHANGE AND ORGANISATIONAL CULTURE

Working within the limitations that the environment offers, the RN is also in a position where change and culture are inherent components of the work day. Change is part of the everyday workings of the modern organisation. Nothing is static and many practices, policies and external drivers change on a constant basis. This change is visible in the physical environment, through staff and staff relations, and from the external environment. Staff must be well-informed and included in the decision making process and resulting outcomes (Chreim et al., 2010; Dearmon et al., 2015; Klein et al., 2006). Chreim et al. (2010 p. 189), identified through observational assessment, that change agency and distributed leadership are derived and coordinated in a manner where '... change is not being driven by an individual leader but that different actors are involved in moving the changes'. This conveys a message and is supported by the qualitative case study presented by Dearmon et al. (2015) that communicates outcomes in relation to staff with how difficulties can present when change is apparent. It is the breadth of the literature relating to change that articulates that both time and people are the key factors involved in the construct of leadership in a work setting.

The evolution and development of change agents involves individuals as a primary catalyst to review, change or empower staff through leadership. This evolution occurs through both direct and indirect communication with the involved parties. Through direct communication and liaison, through education, and through

policy drivers and individuals acting as the catalyst, organisations are able to clearly articulate and view the challenges and barriers to change and capacity for change in the workplace. It is the engagement of staff early in the process that provides the key foundation to the empowerment of staff, and in identifying key change agents in the process. Although the engagement process works well in some instances a number of studies identify that sometimes a specific individual appointed to facilitate this change is required (Dearmon, et. al., 2015; Jackson & Parry, 2008).

The culture of an organisation be it either negative or positive plays an important role in the impact of leadership in an organisation. Culture '... emerges from the collective social interaction of groups and communities' (Meek 1988, p. 459). It is both the organisation and the individual's response to these interactions and changes that shape the culture and determine what response will arise. A culture ready for change requires an individual to have agility, adaptability, be conducive to learning, be knowledge rich and values based as well as to be customer focussed (Hill et al., 2011; Kanter, 1982).

Working in residential aged care nursing teams is complex with care provision undertaken through a minimum of three core staffing divisions, the UHCW, the EEN and the RN. Team dynamics form an essential part of working in any team. The team dynamics that present from working in organisational teams are healthy and form key components of the social learning and work cycle, however at times challenges arise from influences from either within the organisation or external to it. It is at this time in a team that care and attention is needed to ensure that stability is re-established and that relationships are maintained and not frayed at the edges. Healthy challenges occur through cultures of enquiry where people are open to having their thinking and subsequent actions challenged through critical conversation, discussion, dialogue, inquiry and ongoing conversation (Senge, 1993).

According to Smith et al. (2007) it is empowerment that provides the contemporary management solution for cultivating change. When a person is recognised as having authority and has followers who rely on the person's expertise, the person is viewed as a leader. Likewise within the residential aged care setting a UHCW is a leader to residents, an EEN a leader to UHCWs and residents, and the RN is a leader to residents, family and all other team members. Leaders in the

residential aged care settings hold responsibility and accountability for the care provided to residents. A leader innovates, inspires, guides, challenges and empowers within and throughout the team. They are guided by the needs and support of the organisation, however the structure within residential aged care settings quite often remains limiting, disempowering and organisationally complex to the role of the RN.

3.7 A SENSE OF TEAM BELONGING

A feeling of inclusiveness and of being part of a team requires the understanding that the conversations held and decisions made at differing levels in an organisation are communicated, responded to appropriately and are inclusive of the staff they involve. This creates within us, as individuals, the sense of belonging, the wonderment of belonging to part of something bigger, a team, a group or an entity (Baines et al., 2014). Part of the process is the notion of inclusion and secondly, the ability of an individual to be heard. It is a human desire to want to be heard, or at least asked to be included within work, social and family related discussions. The level and degree of involvement will differ from individual to individual, however the inclusive nature of the request offers a sense of acceptance and enablement to individuals (Baines et al., 2014). The feeling of inclusiveness adds to the sense of empowerment or perhaps disempowerment that an individual may experience (Bamford et al., 2013; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006).

This research project is about the voices of residential aged care staff, their inclusion and their experience of RN leadership in that context. However, success in work environments can be more readily gained through positive reflections, a voice that is included and heard, and a degree of empowerment in the work done. In leadership, not all individual traits, characteristics or styles are inclusive in nature, some are authoritarian others quite *lassaiz faire*. It is about the voices that can be heard and what these voices say that matters. To be included in conversations within an organisation is important to employees. It is about the voice, about the ability to be involved in care decisions and in corporate planning. It provides a sense of belonging that creates a personal feeling of pride and empowerment (Bamford et al., 2013; Choi et al., 2011). Working in the residential aged care setting is complex, and as an employee both joy and frustration can be felt. The complexities are great as the

team coordinating and providing care belong to different levels of educational capacity, schools of thought in care provision and education preparedness. All of these parameters influence the work environment and inhibit or enhance resident centred outcomes in care delivery. Feeling good about the care provided, and in the leadership exhibited by the RN adds to the self-empowerment of the team working in the setting.

3.8 STAFF EMPOWERMENT

As staff seek a personal sense of achievement from their work role, a sense of empowerment appears, characterised by autonomy, confidence, meaningfulness and a feeling of being able to have an impact in the organisation and on quality resident care (Holmwood, 2013; Spreitzer, 1995). Chreim et al. (2010), indicates the need for a cohesive approach and one that will take time, persistence, understanding with communication and the empowerment of staff to achieve the required change. Kanter (1977) discusses the notion of opportunity where opportunities for growth, challenges and development within the organisation are offered to increase the knowledge and skills of employees. Workplace conditions reflect the possibilities for learning and also the prospect of advancement in the organisation. For an RN in residential aged care, the opportunities for advancement remain limited unless movement into a management or quality position is desired. It is these positions that further detract the RN from frontline care and into more administrative based management type positions. The literature is clear that the numbers of RNs in the aged care sector in Australia undergoing further education and training is low (King et al., 2013); coupled with the prospect of limited opportunity for advancement, the drive to improve is somewhat negated. However, research involving staff in the aged care setting clearly articulates the desire to improve standards of care, achieve organisational goals and best practice standards for residents as they age (Davis et al., 2009; Hasson et al., 2008; Johnson et al., 2009). This dichotomy of perspectives aligns with Kanter's organisational theory and is suggestive that staff are willing and keen to engage and improve skills and knowledge, however the organisational structure appears to be the disempowering entity that is creating a resistance, or lack of energy from staff (Kanter, 1977, 1981, 2011).

Research conducted by Laschinger and Finegan (2005) has shown that workplace empowerment has a strong impact particularly on factors related to recruitment and retention, including job satisfaction and organisational commitment. Intricately woven into the empowerment of staff in organisations is the need to hear from them. The voices of staff provide an avenue for staff to be heard, appreciated, further understood and involved in work practice and change in an organisation. A sense of belonging and of being listened to forms part of Kanter's (1977) theoretical framework, as it intuitively prescribes a sense of inclusion and links staff with organisational structures where decision making capacity is often centred. The framework further articulates the need for staff to be able to access lines of information, lines of support and lines of resources to be effective leaders within a work environment (Kanter, 1977, 1981).

To be empowered, staff need to be able to access the required knowledge, skills and information necessary to carry out their work (Bamford et al., 2013; Chreim et al., 2010). In reality this means that staff members require both information that is directly related to their own work, as well as information about the organisation as a whole (Miller, 2001). In the residential aged care setting, RNs are educated and qualified practitioners capable of clinical decision making and, with the ability to proactively solve problems that arise as well as being active participants in change and innovation. On the other hand, UHCWs are less educated; role oriented and focussed on the task at hand or as directed. There is a tendency to 'do' the role they know and understand. Assistance from the RN is gained in managing complex resident care decisions or organisational situations outside the scope of practice of the UHCW. The literature also articulates that the UHCWs in this environment tend to limit their work aspirations, are less committed to the organisation and are cautious and resistant to change (Huai-Ting et al., 2008; Miers & Pollard, 2009). Understanding the UHCW role, its potential and aligning it with career progression opportunities in the sector further enhances the position and encourages staff to engage and develop further.

For the EEN the literature is minimal with the role and scope requiring further definition and delineation (Jacob et al., 2013; Kenny & Duckett, 2005). The EEN is often in a position of leadership in residential aged care with management and control of staff within a section or area of the setting, and in some instances, the

shift coordinator. However it is the scope of practice of the EEN outlined in Australian registration standards that fall outside the realms of patient assessment and care evaluation (NMBA, 2007). With the UHCW assuming more responsibility from medication administration to care provision and the RN assuming responsibility for care planning, coordination and complex needs, the EEN remains in the centre of two expanding positions, creating confusion and role disenchantment (Jacob et al., 2013; Tuckett, Hughes, et al., 2009). How teams work when role delineation is hazy can be complex and yet what appears are a power struggle and a need for a level of ownership and satisfaction in the work being undertaken (Jacob et al., 2013; Kenny & Duckett, 2005).

3.9 IMPLICATIONS OF ORGANISATIONAL THEORY

In the residential aged care setting the aged care team includes RNs, EENs and UHCWs. This type of workforce structure creates a need for strong leadership from the RN role to ensure the creation of work teams that provide quality resident outcomes. There is also a need for EENs and UHCWs to lead components of the care provision and report findings, outcomes or the resident's status quo back to the RN. Kanter's (1977) theory in organisational behaviour provides a theoretical framework for the understanding and inquiry into staff empowerment, power relations, support mechanisms, resourcing, and their effect on care provision within residential aged care settings. The theory provides a pathway for staff to be empowered to achieve, and to feel good about their job. Likewise, the RN and the team in a residential aged care setting can be empowered to achieve organisational, personal, and professional goals through the availability and access to positive and supportive organisational structures. Through these processes and structure a provision of information, support, resources, opportunity, and formal and informal power sources are derived, understood and enacted in the aged care context. This provides an understanding from the theoretical context that provides the research with structure and definition to further explore the voices of clinical care staff in the residential aged care setting.

Chapter 4: Methodology

....it is the essence that makes the music dance.
(Cott, 2013, p. 94)

4.1 INTRODUCTION

Understanding the core concepts of RN leadership as perceived by residential aged care staff is far different to assessing leadership style, or the attributes of a leader or in identifying the weaknesses or deficits in the aged care context. It is not about an individual but rather an assessment of the collective 'what is' of the leadership role of the RN that is seen or experienced in an aged care team. It is known that leadership is an entity, a product of the team, a being in itself (Acree, 2006; Allen & Dennis, 2010; Avolio & Bass, 1999; Bass, 1985; Taunton et al., 1989). An exploration of what the RN leadership role is, is intriguing, and how to explore the 'what is' of this leadership needs to capture the moment, understand the reality, and share the experience from the RNs, the EENs and the HCWs in the aged care team.

The research methodology chapter is divided into three sections. The first section provides an overview of understanding the hermeneutic phenomenological research approach to exploring the leadership role of the RN in residential aged care settings in Australia. The overview provided in section 4.2 provides a descriptive outline of the choice of phenomenology as a suitable research approach to address the research question.

Section 4.3 explains why phenomenology is useful to facilitate the understanding of the lived experience in order to uncover the meaning of the leadership role of the RN in residential aged care. This section incorporates principles of the historical foundations of phenomenology and the prominent phenomenologists, Edmund Husserl, Martin Heidegger and Hans George Gadamer. To understand these philosophers further, discussions have been provided in section 4.3.1 that outline the phenomenon and the use of hermeneutics. As hermeneutics and phenomenology are both human science approaches, engrained in philosophy, a discussion of their philosophic traditions has been presented.

Section 4.4 is a central component to this chapter and outlines hermeneutics as a philosophy of practice to address the research question. The research using a Gadamerian hermeneutic phenomenological approach to inquiry and thematic analysis is discussed in section 4.5. The chapter includes section 4.6 that outlines rigour and its components in a hermeneutic research approach. This section also includes discussions surrounding credibility, confirmability and research bias.

4.2 METHODOLOGY

Aged care nursing is viewed in the literature, media and social domains as a complex area of health (Hill et al., 2011; McKee et al., 2013). Debates continue whether the sector is health or whether it fits the domains of social care and welfare (Baines et al., 2014; Howieson, 2012; Reeves & Macmillan, 2010). It is an area that has great tradition, many attempts at reform and restructure, a heavy regulatory component to care provision, and an ongoing government debate on future requirements, funding and demand (Barnett, 2014; Bellis, 2010; Hughes, 2011). The conceptual framework outlined by Kanter (1977) represents the structure of power and opportunity, the need for both a leader and follower in an organisation and the effect change and organisational culture has on the role of leaders in organisations and in this particular research, the RN in the residential aged care setting. Understanding this construct through the voice of staff enables the researcher to learn more about the leadership role of the RN.

A key driver in any residential aged care setting is the leadership that responds to, and informs the care provided. The RN role provides this position. Operationally, to understand the complexities and assist in work balance improvements, this 'leadership' requires further rich description and analysis to gain a more in-depth understanding. It is this analysis that can enable the RN leadership role in residential aged care to be perceived in a contemporary manner by hearing from the reality of the different levels of aged care staff (Earle, 2010; Gadamer, 2013; Moules et al., 2015).

Research is a means of discovery and explanation, seen to expand existing knowledge on a subject, setting or situation in context with the environment, its people and culture (Benner, 1994; Earle, 2010; Liamputtong, 2013; Sandelowski,

2015). It is through the use of research that new practice can be determined, explored and evaluated, and it is through this evaluation phase that recommendations for practice can result (Moules et al., 2015; Streubert & Carpenter, 2011). Linking evidence to practice in health care is a key component of assuring consumers that practice is contemporary. The assurance is also that practice does integrate with current research findings, and is adaptive within organisations (Liamputtong, 2013; Lincoln & Guba, 1985).

Research can be conducted using either a quantitative or qualitative paradigm depending on what the study requires. Quantitative domains aim to capture the world through the lens of numbers, statistics and objective measurements (Liamputtong, 2013; Lincoln & Guba, 1985). Qualitative research is more concerned with naturalistic inquiry and deals with the issue of human complexity through exploration (Liamputtong, 2013; Lincoln & Guba, 1985; Sandelowski, 2015). In qualitative research it is about the ability to narratively or subjectively understand the human experience in some way or another (Liamputtong, 2013; Lincoln & Guba, 1985; Sandelowski, 2015). It is not concerned with the empirical assessment but rather the dynamic, holistic aspects of human experience (Liamputtong, 2013; Pratt, 2012; Sandelowski, 2015). Qualitative research takes many shapes and forms, and is guided by a suitable methodological framework for the research.

Qualitative research is well established in nursing, midwifery and the social sciences, and provides a thorough and descriptive account of being, and further, lets these entities such as leadership, speak and be heard. Learning from residential aged care clinical staff, and hearing and understanding the RN leadership role from their perspective is key to understanding the role. To successfully utilise a qualitative research approach requires a methodological framework that supports and articulates the, who, what, when, where, why, and how data is collected, analysed, and presented in keeping with the chosen framework.

It is qualitative research that seeks to explore the understanding of human experience in the nursing profession where both the art and science of caring co-exist (Benner, 1994; Gadamer, 2013; Tobin & Begley, 2004). It is about the study of knowledge that addresses the questions of '... what can be known and who can know

it, otherwise known as epistemology' (Converse, 2012, p. 30). It is in the field of nursing that qualitative research methodologies seek to gain a greater understanding of what human experiences are like (Benner, 1994; Gadamer, 2013; Tobin & Begley, 2004).

The methodology used in a particular research project requires thought and understanding of the domain under investigation. This includes how, and why they are important, and in what context knowledge could be gained from the research. Methodology is the process that makes evident the research design and justification. It outlines the principles underlying the research, not the way data is collected (King & Horrocks, 2010; Liamputtong, 2013). Gaining a context for understanding RN leadership in residential aged care settings is greater than pure empirical data alone. It is about gathering information about the experience of the 'what is' of RN leadership to the clinical care staff. It links explicitly with the understanding of what and how individuals operate in their work context and teams.

RN leadership takes place in and through conversations and decision making contexts, as an activity in the everyday life of a RN in aged care (Bergman et al., 2012; Wang et al., 2014). It starts and ends in the realm of a conversation or many conversations, however the 'what is' is far greater than this concept alone. It is linked with the social, environmental and political domains that influence the care provided, and perhaps the decisions made in the setting (Hugo et al., 2009; Ibrahim et al., 2014; Kendig et al., 2010). Kanter's (1977) framework on organisational behaviour discusses the socio political domains of organisations, the people and the influential factors in organisations. .Different people in different positions will experience RN leadership in differing ways, understand and describe it differently, and have a sense of either a positive or negative balance to that experience (Bellis, 2010; Cummings et al., 2014; Hurley & Hutchinson, 2013; Jeon, Glasgow, et al., 2010). How to gather this information from clinical staff in a residential aged care setting and in turn allow the voices of staff to be transcribed to text and analysed is important. It is this information that provides a voice and a level of ownership from clinical care staff at the frontline of care (Liamputtong, 2013; Lincoln & Guba, 1985; Moules et al., 2015).

The choice of methodology sets the scene and creates the foundation for understanding better the notion of RN leadership from the clinical care teams in the residential aged care setting (Liamputtong, 2013; Lincoln & Guba, 1985; Moules et al., 2015). The first step in this process is the ability to hear from clinical care staff, listen to their story, see their environment and relate to the work that is done (Converse, 2012; Dowling & Cooney, 2012; Moules et al., 2015).

4.2.1 The Qualitative Paradigm of Phenomenology

Phenomenology is a qualitative paradigm that attempts to describe and interpret meanings with a degree of richness and depth (Creswell, 2013; Liamputtong, 2013; Lincoln & Guba, 1985). It differs from other qualitative research methodologies in that others do not necessarily focus on meanings but perhaps on relationships among variables, social opinions, or on the frequency or occurrence of particular behaviours. Phenomenology is about the experience of the lifeworld (Creswell, 2013; Liamputtong, 2013; Lincoln & Guba, 1985). It differs from ethnography where meanings are derived from particular cultures, or to certain social groups within sociology, or within a personal biographical account or historical undertaking (Finlay, 2011; Liamputtong, 2013; Moules et al., 2015). There are a number of ways to explore RN leadership in a particular setting such as by exploring leadership styles, attributes or characteristics. Valid and reliable survey tools exist to capture this information and have led to some of the pre-understandings derived from the literature. Recruitment and retention patterns can be objectively explored through quantitative methods to gauge the extent of movement in a particular cohort or sector within industry (Chenoweth et al., 2010; Duffield et al., 2014; Mohle, 2011; Tuckett et al., 2011). Distinct from this, qualitative research offers a way of learning more about the why, or what is, that cannot be extracted from pure quantitative datasets, rather it is about a voice and the meanings that can be gained (Creswell, 2013; Moules et al., 2015; Sandelowski, 2015).

Nursing is a predominately female profession so it could be argued that the use of a feminist methodology would be appropriate (Benner, 1994; Mohle, 2011). Feminist methodology however is focused on women and their concerns, which is '... research that is beneficial for, and about women' (Liamputtong, 2013, p. 11). RN leadership in the residential aged care setting does not fit this methodology in the

context of the research question being asked. It could also be argued that a social constructivist approach could analyse the language, the linguistics in use, and then deduct meaning attributable to this (Green & Thorogood, 2011). The RN leadership question being asked is greater than just the language or conversations. It is also the environment, political, social and cultural structure that adds to the meaning of the words or language used. In determining the methodology it was about seeking an understanding of the question being asked. This research is about the exploration, the understanding, the reflection and the determination of gaining a greater appreciation of 'the being', that is RN leadership in the residential aged care setting, in the Australian context.

Phenomenology is well known as a research philosophy and a methodology that aims to give substance to personal experience (Converse, 2012; Dowling & Cooney, 2012; Liamputtong, 2013; Lincoln & Guba, 1985). That is, it attempts to find meaning in the everyday life people lead (Van Manen, 2014). It seeks to answer questions of meaning in understanding an experience, in this instance the RN leadership in aged care. According to the phenomenological work of both Heidegger and Gadamer, phenomenology takes place '... through the constant reworking and revisiting of prior interpretations and, within the analysis of texts, an interdependent moving between parts and wholes' (Rosenblatt, 2008, p. 233). Phenomenology was selected to explore the research question through a process of interpretation, clarification and understanding. This process provides the ability for data to be analysed to gain an understanding and an interpretation of the leadership role of the RN working in residential aged care settings.

The methodology is concerned with how the world is experienced pre-reflectively, and pre-verbally in its lived immediacy (Converse, 2012; Gadamer, 2013; Smith et al., 2013). As well as describing experience, hermeneutic phenomenology seeks to draw out the meaning or significance of practical involvements in the world. It is these questions of the everyday that Gadamer refers to as addressing the understanding of the experience of being (Gadamer, 2013; Moules et al., 2015). It was the experience and meaning of RN leadership in its working context of residential aged care settings that was important to reveal.

Hermeneutic phenomenology was phrased by Schleiermacher in 1833 as a cycle, where each component is understood '... out of the whole to which it belongs' (Rosenblatt, 2008, p. 233). It is the discussion of a cycle, that is, a process that does not end, but sequences in a way of discovering new knowledge from the process of hermeneutic analysis. It is hermeneutics that invites the participants to conversations, and the understandings derived from this are ascertained from the analysis of the dialogue through a fusion of horizons (Earle, 2010; Gadamer, 2013; Koch, 1995). It is this fusion of horizons that interprets the world of RN leadership through the pre-understandings of the researcher and the interpretative framework of the information obtained from participants (Converse, 2012; Koch, 1995; Moules et al., 2015). The participants provide their self-interpreted construction of their experience of RN leadership in the residential aged care setting from within their scope of practice and understanding of the world in which they work. It is through the interpretation of this dialogue that meaning and knowledge can be gained.

Working in the aged care industry as an RN is complex. The literature has identified the complexity in the role of the RN and the aged care environment (Baines et al., 2014; Bishop, 2013; Sonaware, 2015; Walmsley & McCormack, 2015). The caring for individuals is done at a time in a person's life when their autonomy and ability to be independent has diminished either wholly or in part (Brownie & Horstmanshof, 2012; Kendig & Duckett, 2001; Kendig et al., 2010; King et al., 2013). The result of this loss leaves the individual with the need to entrust their care requirements to others in the safety of a residential aged care setting (Brownie & Horstmanshof, 2012; King et al., 2013). It is this sense of loss, and the grief process that commences for both the individual and the family that add further complexity to the social domains of residential aged care nursing. It is also a field of nursing often responsible for large numbers of residents, with the majority of hands on care provided by UHCWs supervised in whole or part by the RN (Bishop, 2013; De Bellis et al., 2013).

Following key accountabilities in the registration requirements of the RN, they are 'the being', accountable for the care provided to residents and the key coordinator of the team that initiates and provides the care for residents (Cummings et al., 2010; Martin & Waring, 2013; NMBA, 2016b; Wilson et al., 2013). It is the RN that communicates through and with members of the care team and the broader

organisational hierarchy. However the RN leadership is greater than the conversations held, and is also inclusive of the interactions, the environment, the systems, the politics and the structures that exist (Caspar & O'Rourke, 2008; Kanter, 1977, 1981, 1982, 2011; Wagner et al., 2010). How all these concepts come together as the culture of an organisation, its meaning to staff, and how this captures the perspectives on what the leadership role of the RN is in this setting, is important. This research sought to find an understanding of the 'what it is, how it is, and perhaps why it is' of RN leadership in residential aged care from a humanistic perspective (Gadamer, 2013; Moules et al., 2015).

4.2.2 Phenomenology…Discovering the Essence

The descriptive nature of Husserlian phenomenology seeks to discover the essence of a phenomenon, that is, to seek a new understanding from within it. It is within the notion of Husserlian phenomenology that preconceived ideas must be 'bracketed', or simply, left at the door, and not be included as an influencing factor to the analysis of the text, or to the linguistic or semantic meaning that is gained (Dowling, 2007; Dowling & Cooney, 2012; Lincoln & Guba, 1985). Husserlian phenomenology is based on the premise of coming to know, through the actual experience of a phenomenon, with a goal of being able to provide a description of the phenomena of interest. It is this methodology that removes the researcher's pre-conceptions of the phenomenon so to experience it in its true essence (Dowling & Cooney, 2012; Koch, 1995). This research engages the preconceptions of the researcher with the knowledge and understanding of the nursing specialty of aged care, and with the knowledge and understanding of the terminology used by staff in their descriptions of the environment and the leadership role of the RN. These areas are not bracketed and the research does not align with the phenomenological paradigm as discussed by Husserl.

The Heideggerian approach to phenomenology however differs in context as preconceptions are not removed but rather inclusive in the analysis process. This notion asserts that people can only be understood in their world, and as such, it is important for the researcher to become aware of preconceptions (Benner, 1994; Earle, 2010; Lincoln & Guba, 1985). Key to this is the interaction between the researcher, the text, the analysis, and the interpretation generated from the clinical

care staff interviews and the textual constructs obtained. The sharing of meaning amongst people within communities is a fundamental tenet of the hermeneutic phenomenological approach (Atsalos & Greenwood, 2001; Lincoln & Guba, 1985; Smith et al., 2013). The linguistic meaning derived from the narratives, the text, and the semantic meaning is attributed to what is felt or initiated by the researcher in the analysis phase (Gadamer, 2013; Lincoln & Guba, 1985; Smith et al., 2013). It is anticipated that the use of a hermeneutic phenomenological approach in this research enables a deeper understanding of RN leadership, as experienced by the clinical care staff. It was anticipated that a clearer insight would be gained into what it means to be an RN leader in the residential aged care setting.

4.3 HISTORICAL FOUNDATIONS OF PHENOMENOLOGY

Phenomenology is deeply engrained in history and tradition, quite similar in nature to that of the residential aged care sector in Australia. The process follows a qualitative design of data collection, analysis and writings. Phenomenology will enable the experiences of clinical care staff to be heard, and used to seek an understanding specifically of the context of the setting, its socio-cultural and historical traditions. The focus of attention on RN leadership, or the 'what is' of leadership as determined by the clinical care staff in a residential aged care setting, requires exploration. It is this depth of analysis that captures or grasps meaning to the '... everyday world individuals experience' (Liamputtong, 2013, p. 8).

The historical roots of phenomenology evolved through the German philosopher Edmond Husserl (1859 – 1938). The term phenomenology can be seen much earlier than this, with historical underpinnings within the works of philosophers like Kant, Hegel and Mach (Earle, 2010; Gadamer, 2013; Lincoln & Guba, 1985). Husserl remains acknowledged as the founder of the phenomenological stance and, of the terminology used within the method of lived experience (Koch, 1995; Lincoln & Guba, 1985; Mapp, 2008). Husserl's motivation for phenomenological enquiry was derived from the belief that pure scientific research of objective data could not be used to understand and study all human phenomena, and particularly the experience of a part of an individual's world (Gadamer, 2013; Lincoln & Guba, 1985). His notion established the need for a more humanistic approach that explored the understanding of self, within the world, in a

way that provided an appreciation and clarity of expression from those experiencing it (Dowling & Cooney, 2012; Lincoln & Guba, 1985; Pratt, 2012). In defining phenomenology Husserl asserts that it is '... the science of pure consciousness' that seeks to '... describe the manner in which the world is constituted and experienced through conscious acts' (Earle, 2010, p. 287). Phenomenology therefore seeks to develop insights from the perspectives of those involved, by detailing their lived experience of a particular time in their lives (Lincoln & Guba, 1985; Moules et al., 2015). This leads to the analysis of searching for meanings, the essence of the experience.

Husserl refers to a phrase *Au den Sachen Selbst* in his works meaning *'... the things themselves'* and *'... let's get down to business'* (Earle, 2010; Malpas & Zabala, 2010; Van Manen, 2014). This notion bears the concept that knowledge comes into being, that is, how it is experienced and in what way it is descriptively detailed. Husserl's phenomenology is also seen within the realms of transcendental phenomenology. Transcendental phenomenology enlists core components within understanding including intentionality, eidetic reduction and constitution of meaning (Earle, 2010; Malpas & Zabala, 2010). Each of these components has core purposes within the methodology to add to the rigour and detail in sustaining the theoretical underpinnings that Husserl espouses.

Intentionality refers to '... the human capacity for awareness of objects as well as their contextual features' (Earle, 2010, p. 287). This concept relates to the clinical care staff and their awareness of the role the RN plays in leading teams in the residential aged care setting. It enables reasoning about RN leadership within the context of the residential aged care setting and to communicate this with others. Van Manen (2014) affirms that to know the world is to profoundly be in the world in some way. For residential aged care staff being in the world is being immersed in the day to day care and the access and knowledge exhibited in the role that is the RN, EEN or UHCW.

Van Manen (2014) suggests to know this world, that is the world of RN leadership in residential aged care, one must first be in this world. Presumptions or assumptions can be derived from theories of leadership and an understanding of what is required from the role of the RN, however real understanding of the context, the

leadership, and what this really is, can only be derived from the exploration of the experience through the voices of the clinical care staff that live in that world.

The term eidetic reduction is important as it is this notion that forms an ideological shift in understanding and practice from Husserl to Heidegger and one that changes the way in which research is analysed. Eidetic reduction refers to the 'bracketing' of our understanding or natural attitude towards a particular phenomenon in order to filter human consciousness, and to discover the essence of the phenomena (Koch, 1995; Lincoln & Guba, 1985; Salmon, 2012). Bracketing involves the removal of the researcher's own preconceptions so as not to influence the interpretation of the participant's experience (Liamputtong, 2013; Lincoln & Guba, 1985; Mapp, 2008). The use of eidetic reduction seeks to understand the experience, not judged or analysed by preconceived or theoretical constructs and to create a descriptive analysis of the lived experience in a detailed descriptive manner.

The notion of 'constitution of meaning' refers to the identification of the essence or structures that create the experience of the life-world (Dowling, 2007; Koch, 1995). The essence derived within a Husserlian approach is descriptive, returning things to themselves. Thus methodology inspired by Husserl is about describing the experience of the phenomenon, often referred to as descriptive phenomenology (Dowling, 2007; Koch, 1995). The evolution of phenomenology further developed as philosophers sought greater understanding in the concepts of description. Within the understandings of all philosophies surrounding phenomenology, the drive is always in the search for the understanding of a phenomenon. This understanding derived through research, analysis and a final description is seen and felt by those understanding its relevance (Dowling & Cooney, 2012; Gadamer, 2013; Moules et al., 2015).

4.3.1 The Phenomenological Approach of Heidegger

Heidegger, a German philosopher and assistant of Husserl's believed that phenomenology should be used to investigate the 'what is' meaning of being. The approach by Heidegger differs in that the researchers bring their own understanding and experiences to the research process. This process differs from Husserl who asserts the use of 'bracketing' within his method. That is, Heidegger's focus is

ontological as opposed to Husserl's epistemological focus. Heidegger utilised the terminology *Dasein* or the situated meaning of being part of the world rather than bracketing the world surrounding the question being explored (Dowling & Cooney, 2012; Gadamer, 2013; Koch, 1995). For Heidegger, it was more than the discovery and discussion of the essence but looking more at what was the 'being'. Heidegger was concerned with what the meaning of individuals understanding of the 'what is' that makes us what, or who we are (Lincoln & Guba, 1985; Moules et al., 2015).

Unlike Husserl, Heidegger stated that what is to be uncovered '... is not the essence of the phenomenon, but rather the 'being' of the phenomenon' (Converse, 2012, p. 29). The Heideggerian experience is more concerned with the understanding of what makes entities what they are, as it was Heidegger's belief that the world is an integral part of the way we understand our being (Converse, 2012; Moules et al., 2015). That is, Husserl essentially removes a person from the world of the phenomena being explored where Heidegger immerses the person in the world of understanding (Gadamer, 2013; Koch, 1995). It is from this understanding that people make sense of their world from their perspectives of reality, whilst attached to the world they understand. Heidegger uses the term pre-understanding to describe the '... organisation of a culture, its language and practices that is already in the world before we understand' (Dowling & Cooney, 2012, p. 24). In this sense, pre-understanding cannot be bracketed because it already exists and interpretation occurs with the '... understanding that the researcher is part of the historical, social and political world' (Converse, 2012, p. 29). Heidegger also believed that in determining the nature of 'being' the process was a never ending circular process. This concept is referred to as a hermeneutic circle.

4.4 HERMENEUTIC PHENOMENOLOGY

Hermeneutics is derived from the 'Greek verb *hermeneuein*, which means to say or interpret' (Moules et al., 2015, p. 2). Hermeneutics then, is the search for the essential meaning of 'being' rather than the quantitative search for truth. Hermeneutics more broadly describes '... the tradition, philosophy, and practice of interpretation' (Gadamer, 2013, p. 3). Meaning is thus attributed to the text through reading, coding and analysis of the text, and of the decoding of the signs and symbols of the text. The premise of hermeneutic phenomenology allows for shared activity

between pre-understanding and understanding (Gadamer, 2013; Koch, 1995; Lincoln & Guba, 1985). It does not exclude what is known, the environment and any pre-conception that people have, but rather evolves from, and within these notions to deduct a connection or analysis of the 'being' rather than the descriptive essence of Husserlian methodology. Simply, hermeneutics can be described as the tradition, philosophy and practice of interpretation (Gadamer, 2013; Moules et al., 2015).

This practice of interpretation is concerned with the whole understanding of the phenomena, which is inclusive of all the forms that create and make the phenomenon. It sees more than the language, it considers the contextual world of a word, firstly what is said, and also inclusive of what is not said. This distinct difference to the Husserlian notion allows for the inclusion of parts of the world that make sense to the being. It recognises the concepts that ring true of what has been said, so that there is a permeating resonance of familiarity and difference. Hermeneutics requires '... bringing forth and a bringing to language of something new' (Moules et al., 2015, p. 3). Through hermeneutics a focus on the topic of RN leadership in the residential aged care setting was able to be explored specifically in relation to how it was lived in the world, in this respect the environment of clinical care staff working in residential aged care settings. It is then that the analysis deepened to gain an understanding of this world and how its impact relates to the setting, and of what significance this was to the clinical care staff and the leadership role of the RN.

It was in learning more about the phenomena sometimes something new, sometimes reaffirming what was known and other times understanding the contextual text with a new lens that outlines an offering of a new something of both individuals and the world the phenomena evokes. It is a process that begins in interpretation by broad understandings or fore-conceptions and continues on a cyclical journey replacing, evolving and understanding in greater depth and context the conceptions as they present, re-present and gain depth (Earle, 2010; Lincoln & Guba, 1985; Moules et al., 2015). It is the hermeneutic cycle that '... rather than end, is replaced with interpretation, clarification and understanding' (Rosenblatt, 2008, p. 233). It is this that provided the pathway for interpretation and analysis, and further interpretation to divulge meaning, uncover the being to answer the simplistic nature of the 'what is' question.

Alethia is a term central to hermeneutics that refers to '... the event of concealment and unconcealment' (Moules et al., 2015, p. 3). It occurs when something is opened that has been closed or not visible to others. The terminology has Greek roots with 'lethe' referring to a river where the story goes that if the water is consumed; the person is unable to recall their past (Moules et al., 2015). It is also linked to the word 'lethal' defined in terms of death or end of life. With such a macabre meaning, it is perplexing to find its use within hermeneutics and the world of research. It is used within the hermeneutic analysis as a way to describe bringing to life what was once seen as dead. It is a process of remembering what was forgotten or lost to an individual, environment or business and about reinvigorating what is seen as '... the way things get done around here' (Earle, 2010; Lincoln & Guba, 1985). In this sense, it is about the understanding of the experience of RN leadership not of the concept of leadership in the setting. It therefore is about questioning those things that are inherently taken for granted, seen as everyday and routine and presume they continue tomorrow without too much thought (Gadamer, 2013; Moules et al., 2015; Van Manen, 2014).

The premise is then to come to an understanding, that leads to questioning the everyday and to explore a particular experience of being (Earle, 2010; Lincoln & Guba, 1985). This is a question of many aspects and one that is interesting in the concept of RN leadership in residential aged care settings. The literature is broad in the studies conducted, and significant areas of the literature outline the objective nature of leadership, its effect on recruitment and retention of staff, its value and what style fits this organisation or business group comparative to the next (Duffield et al., 2011; Hayes et al., 2012; Kleinman, 2004; Venturato et al., 2007). The literature provides a lengthy discussion with a focus on business, productivity and outcomes, many in terms of business and fiscal processes or human resource management (Anderson et al., 2003; Crilly et al., 2012; Scott-Cawiezell et al., 2004). What is more interesting is at what point is the discussion about, and inclusive of, the clinical care staff in a residential aged care setting? What is it staff see, do, and are engaged in that affects or develops a repertoire of staff experiences of leadership in the space they work? What can be discovered from what is concealed, or what meaning can be derived from the everydayness of this leadership, remains in many respects a mystery.

It is not an uncommon scenario to hear that leadership courses or staff development opportunities are available and staff are identified to attend an education program (Bajnok et al., 2012; Begley, 2009; Dickson & Tholl, 2014; Dignam et al., 2012; Missen, Jacob, Barnett, Walker & Cross, 2012). It is in such education sessions that staff learn about themselves, understand how they work and perhaps their personal communication style (Dickson & Tholl, 2014; Hallinger, 2003; Lynch & Verner, 2013). It is then that the course takes a pathway of sharing great leadership styles, offering the attributes of leadership and how to succeed based on the premise of the characteristics or attributes that one must aspire to (Aberdeen & Angus, 2005; Forman, Jones, & Thistlethwaite, 2014; Phillips, 2005; Sherman, Bishop, Eggenberger & Karden, 2007). However successful these education programs are, and there is no doubt that something is learnt from them, education alone fails to help develop leadership from within the role (Aberdeen & Angus, 2005; Dignam et al., 2012). It is the clarity of understanding of the 'what is' that creates a sense of great leadership. Great leadership is something learnt and is derived from within the individual and shared with those around them (Bergman et al., 2012; Drescher et al., 2014; Walker et al., 2011). It is this that creates a presence that provides the sense of security for staff (Bergman et al., 2012; Drescher et al., 2014; Walker et al., 2011). The use of the phenomenological hermeneutic cycle to explore this phenomenon was interesting, fitting, and inclusive of the world of RN leadership in the residential aged care setting.

4.4.1 Hermeneutics as a philosophy for practice

Hermeneutics begins by detailing and describing the theory of the method first conceptualised by Gadamer (2013). Gadamer's (2013) hermeneutic theory is concerned with the dynamic relationship between the part and the whole, a process of uncovering, understanding and discovery (Creswell, 2013; Dowling & Cooney, 2012; Gadamer, 2013). It provides a circular not lineal style of thinking and of analysing text. The naturalistic phenomenological inquiry provides the search for the meaning and essences of the experience of the RN leadership role. This meaning obtained from the narrative captured through first person accounts from clinical care staff in residential aged care settings.

The use of the terminology ‘experience’ is in itself elusive. In a true sense, the moment of the experience cannot truly be captured; rather it is witnessed following a said moment in time (Gadamer, 2013; Smith et al., 2013). Time does not wait, and moment by moment our world is viewed by what people see, what people hear, and how people behave (Van Manen, 1990, 2014). The action of work within our lives consumes a large proportion of our day. It has both a social and professional context and creates an internal understanding for staff of what is seen, heard and done. It is these influences and work patterns that help to shape perspectives of the workplace. Working in the space of a residential aged care setting can be challenging. Providing leadership in this context must also be challenging. Listening to the UHCWs and EENs working with the RNs, and from the RNs themselves, allowed the researcher to become absorbed in the ‘what is’ of RN leadership in the residential aged care setting.

Interpreting research through the paradigms of hermeneutic phenomenology is about describing and interpreting meanings to a degree of depth and richness (Benner, 1994; Lincoln & Guba, 1985; Salmon, 2012). The textual construct and the interpretation of these are at the fore to understanding meaning. This approach to textual analysis explores the interrelationships between the researcher, the text and the context (Benner, 1994; Lincoln & Guba, 1985; Salmon, 2012). The emphasis is in finding common ground, ‘... shared meaning and consensus in a manner that stays true to the text and honours the lived experience of the research participants’ (Benner, 1994, p. 57). Hermeneutic analysis is the exploration of, and understanding of, what it means to be a person in a given situation (Moules et al., 2015; Salmela et al., 2012). It provides an analysis by which common patterns or shared meaning can be interpreted from the descriptions of human experiences (Pearson et al., 2007; Van Manen, 2014). The premise practises the philosophical belief that human knowledge and understanding can be gained from analysing the pre-reflective descriptions of people who are living the experience in question (Benner, 1994; Dowling, 2007; Liamputtong, 2013; Lincoln & Guba, 1985).

In phenomenology, the truth arises in the mere appearance of what is deemed reality. To explain residential aged care RN leadership at a time in Australia that reflects a period of political and social reform for aged care, with the growing demand for care requirements, an aging population, and the increase in consumer

demand for quality service, is much more than a mere description of its existence (Angus & Nay, 2003; Kendig & Duckett, 2001). This is not surprising as descriptions form the base of a discussion; however it is the explanation or analysis that identifies the experience, the meaning of the being that requires a greater knowing (Earle, 2010; Lincoln & Guba, 1985). This explanation and analysis provides the deeper understanding of the phenomena, links to the discussions arising from Kanter's perspective of organisational structure and empowerment, and is inclusive of the culture, in conjunction with the spoken and unspoken text (Earle, 2010; Lincoln & Guba, 1985; Kanter, 1981, 2010).

4.4.2 Gadamer's premise of hermeneutic phenomenology

The reality of phenomenological inquiry is not always that we know too little about the phenomena but rather we know a lot about it (Van Manen, 1990). Nonetheless, it is how the experience is analysed and presented that changes the meaning, enriches what participants see as 'the experience' and discovers the 'true' meanings. Our '... common sense, pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge predispose us to interpret the nature of the phenomenon' (Van Manen, 1990, p. 46). That is, '... good interpretative work should disclose something about the meaningful existence of the interpreter and the world' of the research in which the interpreter is immersed (Moules et al., 2015, p. 119). This fit with Gadamer's premise of hermeneutic phenomenology serves as a practical philosophy; a philosophy that takes into account the humanistic component, an area inseparable from understanding. For Gadamer, this gives opportunity for understanding the direct relevance to how people navigate aspects of their existence (Gadamer, 2013; Moules et al., 2015).

The works of Gadamer provided direction for this research, its method and analysis. The philosopher Hans-Georg Gadamer, a German scholar further developed hermeneutic phenomenology from the work of Heidegger during the 20th century (Gadamer, 2013). Gadamer extended the work of Heidegger and the notions of being in the world. He moved phenomenology to a world of practice where pre-understanding was no longer bracketed but rather utilised within the hermeneutic process. It is through this premise that all understanding arises from within and through our prejudices (Converse, 2012; Earle, 2010; Gadamer, 2013). By this,

Gadamer referred to the terminology of 'prejudice' in a positive sense of our pre-understanding of the world we live. Although, philosophically grounded within the work of Heidegger, differences remain within the approach Gadamer prescribes. Through Gadamer two key concepts are introduced within his philosophy, known distinctively as prejudgement and universality (Gadamer, 2013; Lincoln & Guba, 1985).

The notion of prejudgement is used within the hermeneutic approach of Gadamer, unlike Heidegger who asserted that our '... understanding proceeds from our preunderstandings and forestructures' (Moules et al., 2015, p. 121). The phenomenological works of Gadamer further challenge this notion and explain the understanding that prejudices or presuppositions exist before all other learnings are obtained. That is, the researcher has an understanding prior to the examination of the question at hand. In this research there is an understanding that the researcher is aware of the role that the RN occupies in the residential aged care space. However, in this knowing the researcher is able to understand, or situate themselves within the area being examined.

Nursing is a discipline of the sciences and with this expends a particular nuance within language, within processes, and within the understanding of what is spoken within the text and thus the voices of staff (Benner, 1994; Donohue-Porter, 2014). It is for this reason that our prejudices allow us to hear something that otherwise may be lost, or simply missed in transaction. It was these nuances that allowed the researcher to recognise and access the world of the RN leadership in residential aged care. Moules et al. (2015, p. 121) affirm the notion that '... we cannot know anything other than subjectivity, and it is our prejudices that help in allowing us this particular view'. To bracket this information would offer no great insight and the likelihood of a loss of true contextual understanding. It is a process of reflexivity that enables the researcher to enter the space, seek conversations and gain the text to be informed and understand the setting, the context and the clinical care staff (Gadamer, 2013; Moules et al., 2015; Tobin & Begley, 2004). This by no means offered a way of leading clinical care staff to the text or to conversations in a particular direction. The understanding and informed context quite contrarily allows for the more delicate of conversations, the understanding of the language of nursing, and the knowing of the context of the residential aged care nursing space. Gadamer

maintains that it is better in hermeneutic phenomenology grounded research to '... position oneself as an individual in relation to the topic, rather than as a representative of the broad categories' (Moules et al., 2015, p. 122).

Gadamer believed that there was no single objective, true interpretation, but that the researcher always comes from a particular perspective (Converse, 2012; Gadamer, 2013). Likewise, within the premise of Gadamerian phenomenology understanding is something that is already there, to some degree or point, so starting with no thoughts, premises or understanding is not plausible (Gadamer, 2013). It is through the notion of prejudices that Gadamer asserts that we must have prior understanding that comes to the topic or as Gadamer refers to it, what brings us to the topic (Converse, 2012; Gadamer, 2013; Moules et al., 2015). It is in this transparency that greater learning and understanding of the contextual and textual constructs can be analysed and interpreted to bear a meaning that offers, in itself, benefit to the individuals involved.

Universality refers to the notion that within hermeneutical phenomenological research pertaining to the works of Gadamer, that in essence there is no beginning nor an end to the understanding (Converse, 2012; Gadamer, 2013; Moules et al., 2015). This notion of an incompleteness of understanding is derived from the knowledge that the researcher enters the research with a notion of understanding prior to the commencement of the research (Gadamer, 2013). Further to this, is the understanding that data analysis is a process, one of uncovering, one of discovery and of re-discovery (Dowling & Cooney, 2012; Gadamer, 2013).

Through universality, Gadamer identifies that the point at which the 'what is' of a particular phenomenon comes into understanding through the collective use of language is key (Gadamer, 2013; Moules et al., 2015; Tobin & Begley, 2004). It is this understanding through language that posits '... a universal ontological structure' (Gadamer, 2013, p. 470). It is through this structure that meaning is derived through the understanding in language that presents the perspectives that detail the 'what is' of the experience by the participants. The climax of reaching the position of understanding occurs through the written form of the language, the knowing and the understanding of the interpretation (Converse, 2012; Gadamer, 2013; Moules et al., 2015; Tobin & Begley, 2004).

It is the researcher who is immersed in the social, cultural and historical world, and this situatedness needs to be considered when interpreting the text and analysing this further for textual notation and explanation (Gadamer, 2013; Pratt, 2012). The exploration of the 'what is' is key and the reality of the researcher's situatedness within the social, cultural and historical world of nursing and leadership provides the underpinning reason for this exploration.

The topic of RN leadership occurs in all areas of clinical practice. It is not set aside from, and does not occur in isolation to the everyday care provided in a residential aged care setting. Rather it is an integrative process that happens every shift. The underpinnings of the practice philosophy of Gadamer are well known within the scope and field of hermeneutics in practice (Earle, 2010; Koch, 1995; Lincoln & Guba, 1985; Moules et al., 2015). In its methodology it is not clear or grounded in any specifics, however Gadamer suggests that to proceed one must be guided by a topic, there needs to be questions to be answered or a 'showing of questionableness' (Moules et al., 2015, p. 5). Put simply, the notion of RN leadership in residential aged care settings is known to exist, is documented in the literature and explicitly linked to accreditation standards, provides key care accountabilities in the sector, and is seen as the leading influence in a highly dominated UHCW domain in caring for the aged (Huai-Ting et al., 2008; Milson-Hawke & Higgins, 2003). However, greater understanding of this leadership within this context remains questionable.

4.5 HERMENEUTIC ANALYSIS

Understanding hermeneutic phenomenological analysis is principle to understanding the experience of RN leadership in the residential aged care setting. The analysis of the text involved the engagement of the researcher with the data to read and re-read the transcripts (Dowling & Cooney, 2012; Gadamer, 2013; Moules et al., 2015). Data analysis involved in hermeneutic analysis is a divergent rather than a convergent approach (Dowling & Cooney, 2012; Moules et al., 2015). That is, it involved the careful and purposeful opening of linkages that strengthened the understanding of the leadership role of the RN rather than a focus on the development of themes from within the data (Converse, 2012; Moules et al., 2015; Pratt, 2012). For this reason, analysis involved a process of interpretation. This

process of reading and re-reading the transcripts is a dialectical process of questioning the data and the quest for searching for answers from within the text (Gadamer, 2013). The result is the interpretation derived from the hermeneutic phenomenological cycle that provided the portal of what can be known as the analysis.

How the experience is analysed and presented will display the meaning, enrich what participants see as 'the experience' and uncover the findings. Our '... common sense, pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge predispose us to interpret the nature of the phenomenon' (Van Manen, 1990, p. 46). That is, '... good interpretative work should disclose something about the meaningful existence of the interpreter and the world' and of the research the interpreter is immersed within (Moules et al., 2015, p. 119). The evolution of the participants experience unfolded through a process of re-reading the text, of re-interpretation and further interpretation to a juncture where the participants experience of the phenomenon and the 'being' of the researcher come together to reveal new knowledge (Pringle et al., 2011; Salmon, 2012).

4.6 RIGOUR IN HERMENEUTIC PHENOMENOLOGICAL RESEARCH

Ensuring that quality, rigour and integrity are maintained within any research is a priority. The researcher needs to maintain a level of robustness in the research and the ability to translate this throughout the research journey. To achieve quality is often difficult as qualitative research holds the '... view that reality is socially constructed by an individual and that this socially constructed reality cannot be measured, though it can be interpreted' (Liamputtong, 2013, p. 24).

Sandelowski (1993, p. 2), asserts that '... rigour is less about adherence to the letter of rules and procedures than it is about fidelity to the spirit…of the work'. Using this statement to guide the practice and process of rigour it is then about the thoroughness of the research. This thoroughness is inclusive of the appropriateness of the chosen participants, the question being explored, and the quality of the interviews and the completeness of the analysis. It is in the qualitative research domain, specifically those relating to hermeneutic phenomenology, that rigour is not able to show itself in the strict quantitative sense of rigour or truth. That is, '... the

adherence to an inflexible method, or in absolute and precise findings that can be replicated to authenticate them' (Moules et al., 2015, p. 171). This definition, albeit accurate in its wording, is not reflective of the true sense of research conducted within a hermeneutic phenomenological framework. This is not to say that the research does not contain rigour but rather that the definition and prescription of what this rigour is, is defined in terms of the quality of being careful and with a sensitivity to the context of the research in its whole, to maintain a robustness of quality (Moules et al., 2015; Smith et al., 2013; Tobin & Begley, 2004). This process is strongly supported through conversations, through journaling of pre and post reflective thoughts surrounding the interviews, the environment and the context of the setting during visits and meetings (Koch, 1995; Tobin & Begley 2004).

Rigour contains two criteria with specific relation to this qualitative research and include credibility, and conformability (Liamputtong, 2013; Lincoln & Guba, 1985; Smith et al., 2013; Tobin & Begley, 2004). In this sense, the qualitative framework applied to the research requires explicit consent from participants, the need for interviews that are taped, reviewed, member checked by participants and read and re-read by the researcher to gain an understanding and meaning of their purpose, consistently and with transparency (Lincoln & Guba, 1985; Smith et al., 2013; Tobin & Begley, 2004).

The criteria of credibility, and conformability and their use in the assurance of rigour in the research process contain strategies to minimise risk, to ensure honest and accurate reflections and to portray a representation of the meanings in a true to spirit essence of the text, and the voices of the participants. Table 4 outlines the criteria and strategies that have been utilised in the research to maintain rigour. This table is based on the work of Tuckett (2005) and the historical works of Sandelowski (1993) and Lincoln and Guba (1985). A discussion surrounding the application of credibility and conformability in the research has been provided.

Table 4: Criteria and strategies for ensuring rigour within the research

Rigour criteria	Criteria for rigour	Research strategy	Techniques to ensure rigour
Credibility	Truthfulness	Field notes Electronic recording Transcribed script Auditing transcript	Purposeful sampling Member checking Supervisor audit trail
Confirmability	Neutrality Trustworthiness	Research journal/field notes	Supervisor audit trail

Adapted from Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*: California, USA. Sage Publications;
Sandelowski, M. (1993). Rigor or Rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1 – 8; and,
Tuckett, A. (2005). Part II: Rigour in qualitative research: complexities and solutions. *Nurse Researcher 13(1),* 29 - 42. doi:10.7748/nr2005.07.13.1.29.c5998.

4.6.1 Establishing Credibility

Credibility addresses the issue of 'fit' between respondents' views and the researcher's representation of them (Liamputtong, 2013; Smith et al., 2013; Tobin & Begley, 2004). It raises the questions of whether the researcher's interpretation or explanation fits the description, and secondly, whether the description is credible. Credibility can be demonstrated through a number of strategies within the research. These are inclusive of purposeful sampling, electronic recordings of the interviews, transcribed audited scripts through a process of member checks, and audit trails, (Benner, 1994; Smith et al., 2013; Tobin & Begley, 2004).

Audit trails were an important aspect of the research process. The use of an audit trail provided the researcher with a structure to guide the research process (Moules et al., 2015; Sandelowski, 1993). The research design includes six phases, each phase with a specific role in the research. The audit trail provided a means to document through field notes, interviews, transcripts and the course of the analysis a way of tracking the research logic. Each stage of the research was further discussed and reviewed by the supervision team providing assurance and guidance in the research process.

Interviews were electronically recorded to ensure a level of accuracy in the detail that was provided by aged care staff. The interviews were listened to by the researcher many times to ensure that the context of the verbal recording was captured. Field notes were also collected as a journal entry at the time of each

interview that outlined the researcher's reflective summary of the residential care environment, staff conversations and routine of the day. This was used to further understand the context of the examples provided and the tone and emotion heard in the interviews conducted. The accuracy of the understandings derived, the implications for practice and the recognisable descriptions of the research that experts understand, know and can believe to be true (Gadamer, 2013; Koch, 1995; Tobin & Begley, 2004). This credibility is born and understood in the context of the meanings derived in relative understanding of the environment and the profession.

Member checking is a vital technique in establishing credibility (Tobin & Begley, 2004; Moules et al., 2015). The research requires that the transcribed text has been obtained with a participant's written consent. The interviews have occurred following discussion, and organisation of time, place and person to gain greater insight into the role, the leadership, the positives, the challenges and the unheard story of the participant. It is this written word that requires endorsement from the participant, a checking for an individual's observed accuracy. It is also in the ability of participants to engage in greater conversations or to remove information seen as not reflective of their voice (Koch, 1995). The remaining written text is returned for inclusion within the analysis phase. It is at this stage of member checking that participants are able to clarify any commentary contributions to strengthen the accuracy of their voice. Checks and balances form part of the ongoing phase of analysis with meanings shared with selected participants as the meanings develop, grow and emerge from the narratives (Tobin & Begley, 2004; Koch, 1995; Moules et al., 2015).

As Moules et al. (2015, p. 172) outline, external validity is an '... experience of application; it does not arise out of the past, but from the future, becoming something only in the way it is lived out'. Gadamer (2013) asserts that the first component of this is in the rhetoric, the presentation of the analysis, the writing out, and the presentation of the persuasive writing. The writing is done with an authority to share the analysis and not a meaning of trying to convince an audience. The writing seeks to provide the reader of a truthful analysis of the voice of staff. The final product an analysis of the voice and a believable outcome to participants. This believable outcome is transformed in how the research informs practice, has the ability to be embedded within the practice and within the transformation of practice.

This is what Gadamer affirms as important in the external validity of the research, aligned with the ability of the research outcomes to provide further questions surrounding the practice and the transformation (Gadamer, 2013). This type of questioning leads to the veracity of the research, and the revealing of the truth factor in the research. This truth factor is seen in the trustworthiness of the research.

4.6.2 Establishing Confirmability

Confirmability has an inherent link with the notion of trustworthiness (Tobin & Begley, 2004). The main premise in confirmability is that the derived meanings are clearly articulated and interpreted from the narratives obtained from the participants (Koch, 1995; Tobin & Begley 2004). This premise is demonstrated through the use of field notes, and a researcher's supervision audit trail. Data analysis entailed a process of logically representing the data used in the analysis phase to determine the final summation of the meanings that have been discovered. Data analysis occurred through both a manual and cross checking phase to ensure that the key themes or meanings identified were able to be ascertained firstly through a manual process of naïve reading followed by a process of structural analysis (Koch, 1995; Tobin & Begley 2004). In this research the cross checking of information and conclusions phase of the data analysis cycle used NVIVO© software. This cross checking process determined an agreement in themes and a corroboration of the data analysis process. This stage of the analysis process provided a sense of trustworthiness in the themes that emerged.

Trustworthiness in research has linkages with the research questions that are asked and further to how the data obtained is managed during the analysis phase. Trustworthiness is also linked with corroboration. The use of semi structured questions provided guidance to the researcher throughout the data collection phase. It was important in the development of the questions that they were broad enough to generate discussion of the participants' experiences however clear enough to tap the participants experience rather than just the participants' theoretical knowledge of the topic (Streubert & Carpenter, 2011; Tobin & Begley 2004). This was achieved through a process of researching the topic area, the information obtained in the literature review and completing a pilot interview to test the questions that were to be used.

4.6.3 Research Bias

The transparency of the qualitative research process was vital and any predispositions that impaired or altered this interpretation of the data needed to be recognised, and managed (Liamputtong, 2013; Smith et al., 2013; Streubert & Carpenter, 2011). In obtaining data in relation to the experiences of residential aged care staff in understanding the RN leadership role in aged care, it was important that the researcher acknowledged that each participant portrayed a unique perspective of their lived experience. Alternatively, such experience greatly assisted in the data collection, analysis and in the process of interpretation.

Importantly, it was vital to explain that the researcher had no personal association with the organisations involved in the research or with the participants of the research. The potential concern of researcher bias was able to be countered by the researcher's insight in this area of inquiry. This provided the ability of more discerning and insightful findings aligning well with the doctrine associated with the hermeneutic phenomenological methodology in accordance with the premise of Gadamer (2013). The researcher utilised a journal transcript of reflective thoughts and understanding as the research project progressed. It is these entries that provided insightful information to the researcher as the analysis phase of the research commenced.

To assist in the management of bias in the research participants were engaged in a process of feedback and discussion of the researcher's interpretations and conclusions for verification and insight. A further discussion occurred with other people. This included a discussion within the supervision team and with an impartial peer or critical friend. It was this perspective that provided a sense of realness to the research and provided a narrative that was reflective of participants and removed the risk of the researcher's own perspective entering into the analysis.

4.6.4 The Determination of Personal Understanding

A personal understanding from the researcher was seen as important (Malpas & Zabala, 2010; Moules et al., 2015). Their background, knowledge and ability to speak freely with clinical care staff and to understand the language, the setting and the nuances that exist are key (Koch, 1995; Tobin & Begley 2004). This notion, sometimes referred to as a bias, however known within the hermeneutic methodology as a tool of bringing understanding to the topic. It is this understanding

that is of a personal and professional nature that creates awareness within the researcher; a knowing of the balance between the closeness and the separateness. It is this closeness and separateness that is required particularly in the questioning of participants within the interview schema (King & Horrocks, 2010; Smith et al., 2013). The interview is open in approach with questions more to guide the voice rather than to explicitly seek an answer (King & Horrocks, 2010; Smith et al., 2013). It is this open question style that requires the discretion of the researcher, the ability to probe, to identify key concepts and to be able to seek greater thoughts, perspectives and anecdotes in practice in relation to them (King & Horrocks, 2010; Moules et al., 2015).

4.7 CHAPTER SUMMARY

The question surrounding the leadership role of the RN in residential aged care is one of interest to those working in the setting. It is also of interest to those professionals in healthcare and to administrators in the management of human and fiscal resourcing in the sector. The application of a qualitative domain when seeking responses to the ‘what is’ of the RN leadership role is viewed in this respect through the methodological framework of Gadamer’s (2013) construct of hermeneutic phenomenology. Kanter’s conceptual framework underpins the research as the voices of staff share their experiences of the leadership role of the RN in the complex organisational construct of the aged care setting where politics, power, structure and opportunity are real factors present in the day to day workforce. It is these factors that provide the influence and the environment in which the RN and clinical care staff work and it is this environment that plays a role in the leadership voiced by staff in the residential aged care setting.

This exploration and understanding of the ‘what is’ of RN leadership in residential aged care settings seeks to inform staff, management and the broader literature. This writing and the language that is used creates the world of meaning, the understanding and the being as derived from the interpretation, the position of the researcher, the culture, history and literature. Understanding the phenomena is complex with many angles and positions. It is one of a collective immersion from the researcher that enables this universality of reaching the point where understanding happens.

The chapter has discussed the broad paradigm of phenomenology with a further understanding of the hermeneutical phenomenological research approach. Discussion has been provided on the use of this methodology in exploring the leadership role of the RN in residential aged care settings in Australia. The chapter has provided the reasons for the choice of methodology and the suitability of methodology to the research question.

The historical foundations of phenomenology and the prominent phenomenologists Edmund Husserl, Martin Heidegger and Hans George Gadamer have been discussed. A discussion has occurred on the research approach through the incorporation of a Gadamerian hermeneutic phenomenological approach. The methodology is not a precise application but rather a search for the understanding, the uncovering of the meanings as derived from the clinical care staff from four residential aged care settings.

Chapter 5: Research Design

5.1 INTRODUCTION

Through language we can evoke meaning; through communication we can have insight, and from the momentary thought we gain understanding (Van Manen, 2014). Entering the practice domain of the RN in the residential aged care setting provided the privilege of being able to further understand the leadership role of the RN, specifically the 'what is' of the role as experienced by those working in residential aged care.

This chapter discusses the approach to the design and method of the research through an introduction to the phases of the research in section 5.2. The chapter continues in section 5.3 with the ethical implications of the research from both the practical and theoretical guise. Section 5.4 outlines the sample size in the research. The facilities are introduced in section 5.5 and the participant selection process articulated in section 5.6. Finally, the data collection methods are outlined in section 5.7 and the process surrounding data analysis is introduced in section 5.8.

The purpose of the method used aimed to *identify the different levels of aged care staff experiences of RN leadership in the residential aged care setting in Australia.* Secondly, the research sought to *explore the experiences of aged care staff in understanding the leadership contributions and challenges to the role of the RN in the residential aged care setting in Australia.*

Over a two and a half year timeframe, the individuals interviewed varied widely as to their backgrounds, reasons for working in the aged care sector, and experiences of working with or as RNs in the setting. The settings were places where research and staff education was being conducted, an area that the researcher was broadly involved with. This enabled a familiarity with the staff to be established and created a comfortable platform for seeking participants.

5.2 RESEARCH DESIGN

The research design enabled information to be collected directly from RNs, EENs, and UHCWs through the use of semi structured in-depth interviews. Data analysis, or in the case of hermeneutic phenomenology the interpretation of data, led to the determination of key meanings derived from an analysis of the text obtained. A further confirmatory process of identified meaning and analysis was revealed through a comparative analysis of the findings with the literature. Finally, this research and the writing out of the analysis and the interpretations, determined considerations for practice within the context of the RN and the residential aged care space. The formulation of suitably appropriate considerations, albeit responsive to policy, governance and an education perspective, were developed from the emerging meanings and the identification of major concepts from within the data.

The research was a careful assembly of a research question, methodology and a participant group. This alignment of question, participants, and research etiquette was arranged within six distinct phases. It is important to present each of the phases individually.

Phase one of the research evolved as baseline information was gained, assessed and a literature review conducted to ascertain key implications from the literature. It was through reading the literature and having an historical understanding that information were gathered, collated and meta-synthesised. Throughout the conception phase information was collected that was used to develop interview questions, gain background knowledge of the leadership roles and the Australian aged care industry. It was this information that placed the researcher in the context of gaining an understanding of the already known. It was then about preparing for the next iteration of exploration and gaining a greater depth of understanding. The use of information from this phase shaped the research and also linked with the results.

Phase two developed and articulated the interview question and ensured that the chosen methodology was well suited and aligned in practice. The use of Gadamer's (2013) expression of hermeneutic phenomenology takes language and conversation to be the instrument by which individuals engage with the world. The

development of the historical tradition, the rationale for the research and the current understanding of humanistic and heuristic research within this domain, were explored. This phase is connected to phase one of the research, and therefore justifiably incorporated key findings from the literature and professional readings. In characterising the literature and the theory, Kanter's (1977) theory relating to organisational structure and behaviour was used to provide guidance, concepts, and a platform from which the depth of understanding was derived in relation to the organisational context and the open ended style of questioning that was developed.

Phase three pertained specifically to the research design and methods from an operational context. This phase included determining the sample size and aged care facilities for inclusion in the research. The variety of settings chosen was of importance to the research and the researcher. The importance was in the need to identify more than an aged care facility in isolation so that the anecdotes, stories and experiences shared by the staff were not of one particular site, or one particular group of individuals. The research utilised four residential aged care sites. Each site was distinct in relation to resident classification, care, and resourcing, although each facility was geographically located some distance apart.

The completion of ethics applications occurred in phase three of the research design. The determination of participant selection processes and data collection strategies was determined with consideration of the data analysis process to be applied.

Phase four of the research commenced the data collection process. Data collection through the use of in-depth semi structured interviews was utilised to hear the voices of the participants and their stories. This was about their experience, and as such, it remained their story to tell. As one EEN explained, what was important was that there was someone '... t*o listen to our story',* rather than what was described as *'... don't keep band-aiding the system, listen to what we need at the coalface.'*

Phase five involved the analysis of data. The narratives were analysed using the process of uncovering and recovering information, and of discovery through the parts and the whole of the text. Data analysis began in interpretation of broad understandings or fore-conceptions and continues on a cyclical journey replacing,

evolving and understanding in greater depth and context the conceptions as they present, re-present and gain depth. The process evolved as the text gathered was analysed within the domains of a hermeneutic phenomenological premise.

Phase six articulated the considerations for practice. Inherent in this phase was the need to identify policy, governance and education opportunities to apply the information revealed through the analysis or interpretation of the interview transcripts. The interpretation was greater than an empirical number, more than the articulation of theory on leadership into practice and rather the experience as seen, heard and embraced by the residential aged care staff.

5.3 ETHICAL CONSIDERATIONS

Embarking on a research journey with a group of residential aged care settings and participants entailed many considerations with respect to ethics. Phenomenology is about the experience, a participant's moment in time, and the participant's story of how this moment unfolds (Gadamer, 2013; Moules et al., 2015). Maintaining confidentiality and the privacy of the participants throughout this process was vital and how this was achieved was in the intricate details of the research methodology and design. How the research was to be designed, what was anticipated to be achieved and what steps and processes were to be utilised to achieve the research aims and question, needed to adhere to a guiding set of principles to ensure integrity, respect, confidentiality and privacy (Liamputtong, 2013; Streubert & Carpenter, 2011).

Ethics approval was gained from the University of Southern Queensland Ethics Committee and from each individual residential aged care organisation. Appendix A presents a copy of the letter of ethical approval from the University of Southern Queensland. To ensure each facility's anonymity and confidentiality, the letters of ethics approval from the specific organisations have not been included in this thesis. The ethics submissions were based on the moral understanding that the process and practice of the research intent was to prevent harm to participants.

Participants volunteered to become involved on the premise of confidentiality and non-disclosure. The final point in the research was to ensure this privacy and confidentiality of participants in the presentation of the data through analysis,

reflection and understanding. To achieve this required an adherence to the ethical principles of informed consent, privacy, respect and legitimacy in the analysis of the information gained in the data collection process (Creswell, 2013; Liamputtong, 2013).

Maintaining anonymity and confidentiality were of particular concern as access to participants had to be arranged through senior facility staff. Consequently there was a small risk of the participants' identity being known to persons other than the researcher. Translating this obligation into practice was achieved through several processes undertaken at different intervals throughout the research that are described as the research journey unfolds.

The design of the research was such that participants were to be voluntary within the purposeful sampling selection process. Purposeful sampling in the sense that a list of potential participants was provided by each organisation to the researcher. The list was inclusive of the roles and responsibilities and length of time working in the facility. The researcher utilised this list to further refine the request to participants. Each potential participant was given a comprehensive written explanation of the research project (Appendix B) before signing consent to participate (Appendix C). The data collection processes allowed the participants the opportunity to establish a suitable time and place for the interview to occur.

Informed consent was obtained from all participants prior to the commencement of the project and confidentiality ensured by the allocation of a select interview identity number. Informed consent has been described by Liamputtong (2013, p. 39), as '... the provision of information to participants, so that the individuals can understand the information provided, and make a voluntary decision whether to participate or not'. The intent of the consent process aimed to ensure that participants were informed and respected for their dignity and worth. Following this, the use of a pseudonym to further protect and respect the individual was utilised. The initial stages of the research entailed the use of both participant name and identity number until the transcript was member checked by the participant. At this point confidentiality was determined with the allocation of an identity number alone. Confidentiality aimed to conceal the identity of participants (Liamputtong, 2013) and this was achieved through analysis via a select identity

number, not by an individual or a specific facility being utilised. Participants were made aware of the ability to withdraw at any stage without prejudice from the research, by notifying the researcher in writing.

Timing of the interviews was important to both the facilities and the researcher. The consensus through facility discussion and further communication with the volunteer participant group established suitable interview times in a group of different block times. Staff could then choose a time suitable to them. This process provided staff with access to organisationally supported times that allowed staff to have knowledge of the schedule and the availability of the researcher. The interview timeframe was within the 2014 and 2015 calendar year.

The storage of the transcripts was an important aspect for the researcher as it was here that the researcher ensured the confidentiality and privacy of the participant was maintained. Both the transcripts and consent forms were stored and maintained within a locked filing cabinet and in a password protected electronic format with access only by the researcher. The verbally recorded electronic files remained stored in a separate file, password protected again with access only by the researcher.

5.4 SAMPLE SIZE

The residential aged care setting was central to the research. Parameters were selected with respect to locality, organisational structure and the services that each facility provided. In this sense, the need for similarity was important, not so much in the number of beds available but rather in the type of residents being 'cared for'. Important also was the style of staffing model present to ensure a consistency with legislative and regulatory guidelines (Aged Care Act, 1997). This was of particular relevance in the discussion surrounding RN leadership and its meaning to the environment as the complexity of care requirements was clear in the literature as an added burden to health care resources (Bellis, 2010; Choi et al., 2011; McKee et al., 2013).

The determination of participants occurred through a lengthy process of purposeful sampling. A series of meetings, visits and discussions was held with staff, with managers, and with facility management in the determination of a group of staff that appeared to be suitable in the ability to provide detailed, responsive

discussion to the construct of the leadership role of the RN in a residential aged care setting. This careful selection of participants occurred to enable their knowledge and unique characteristics in relation to the topic to be shared. These characteristics considered the inclusion of a participant's experience and employment status within the aged care workforce. In conjunction with the established criteria, and the individual 'fit' for the research question, the selection of the participants also ensured their congruence with a defined inclusion criteria and a willingness to participate. An introduction to the participants is outlined in greater depth in Chapter 6.

The clinical care staff involved in the research were employed across four residential aged care services and had an understanding of the scope and practice of their respective roles within that setting. Twenty-one (21) letters of invitation (Appendix D) were sent to all staff who met the inclusion criteria. It was anticipated that not all potential participants would respond however the researcher was prepared at the outset for an unknown response rate. Thirteen (13) responses were received from individuals willing to participate and share their experiences of the role of RN leadership in the aged care setting. Of the remaining eight (8) of the initial twenty-one (21) contacted, three (3) were on leave at the time interviews were to be scheduled, two (2) declined the offer, one (1) staff member went on extended leave and a further two (2) did not reply to the letter of invitation. The complement of staff that agreed to participate consisted of five (5) RNs, four (4) EENs, and four (4) UHCWs. Staff who accepted the invitation to participate in the research were then provided with further key information in relation to the research. A participant information sheet and consent form was provided to all participants. The overarching aim of the research consent was to inform participants of their obligations and their requirements in relation to the interview and resulting transcript data (Liamputtong, 2013; Moules et al., 2015).

5.5 FACILITY SELECTION

Facilities were chosen that were compliant with Federal government care classifications of high care, low care and respite services (Aged Care Act, 1997). In all settings the care areas included palliative and dementia care capacities, to the extent that all facilities selected had a specific unit designated for the care of residents with dementia. Bed numbers were not a priority. Despite recent Australian

Government changes to classifications in aged care (AIHW, 2013) it was decided to maintain the 1997 classifications in this research project. The recent removal of the classification system per se, has now seen the introduction of a direct funding model focussed towards individual funding mechanisms rather than the historical tiered care approach (AIHW, 2013). This change although reflective of the terminology used, did not change the type of setting or residents being cared for, rather it changed the way funding was distributed in the settings.

In understanding the larger organisational context of each of the residential aged care facilities, it was important to understand the characteristics and philosophies of the respective organisations more globally. Facilities selected also needed to not be involved in competing projects or activities that may have added bias to data collection. Facilities engaged in the research were identified by the use of a pseudonym as indicated within Table 5. The terminology at the time of the research was inclusive of the categorisation of residents as high or low care and not reflective of the recent legislative changes.

Table 5: Organisational structure of approved resident capacity by participating facilities

Facility Pseudonym*	**High Care**	**Low Care/ Hostel**	**Interim Care**	**Dementia Care**	**Total bed capacity**
Facility 1	43	72	variable	36	115
Facility 2	57	80	2	34	137
Facility 3	50	Independent living units available	variable	17	50
Facility 4	81		1	17	82
Facility bed Totals	**231**	**152**	**3**	**104**	**384**

*all facilities were not for profit organisations.

All facilities needed to be governed by large aged care providers in Australia that operated both residential and community based health services. The facilities in turn were managed by not-for-profit Australian organisations. Each facility was locally operated by a Facility Manager with a centralised hierarchy for more strategic planning and group decision making. The broader organisations remained reportable to a Board of Governance that entailed business structures from residential aged care and community care services.

The inclusion of facilities that were consistent in approach and care delivery with what both the literature and the government deemed as a representative facility of the residential aged care sector in Australia (AIHW, 2013; Aged Care Act, 1997). For this reason any chosen setting had current Aged Care Accreditation with no sanctions or major complaints against them, and employ UHCWs, EENs and RNs in the staffing complement (Aged Care Act, 1997).

Engagement with several organisations occurred early in the research after ethical approval was obtained from the University. This enabled discussions with managers to occur. The meetings were conducted in central offices, not within local facilities and engaged members of the strategic management structure. This first step provided assurance, led to more points of discovery in relation to the overarching business premise, and outlined the vision and mission of each of the organisations. These initial meetings led to further meetings with a number of suitable facilities in the different organisations.

With the facilities identified and organisational management in agreement, the next phase involved engaging the individual facilities in preliminary discussions. These discussions were held with each facility manager. Discussions surrounded the intent of the research, its meaning to the facility and the potential selection of participants from within the facility. All meetings conducted proved worthy however with some concerns expressed by facility managers. These concerns centred on what staff might say about the facility's services given the small number of RNs employed.

Despite anonymity and confidentiality being assured, one facility approached declined to participate as a result of these discussions. All other facility managers appeared satisfied with the concept, particularly given the anonymity of both staff and facility in the research. This selection phase resulted in four (4) facilities who met the criteria agreeing to participate in the research.

The facilities are located in a regional city in South East Queensland, a Queensland coastal city, and two locations in South Australia. The use of numbering for each facility was important to ensure the anonymity of the staff participants and

of the organisations. To gain a greater insight into the settings and their services a synopsis of each setting identified has been included.

5.5.1 Facility One

The first organisation is an approved provider of community and residential services and has been for greater than sixty (60) years. The organisation has a strong philosophy surrounding the focus on wellness and quality of life for older people and operates as a not for profit organisation. This premise encompassed a number of elements in the provision of the care that was provided, and was inclusive of understanding residents as individuals, each with their own differences, yet with the need to be involved in their own decisions. The organisation also strongly supported the contribution of the resident and their need for a sense of belonging and involvement.

The residential care services of the organisation were aimed at delivering and coordinating services that promoted wellness in their residents. This notion of wellness encompassed resident activity as well as advocacy for the older person. The services were inclusive of retirement and residential accommodation options, domestic, personal and nursing care in the home, respite choices and short-term transition services. Staff provided care within a social environment that enabled the residents to stay connected and involved in the decision making process. The focus was clearly about celebrating life and enjoying it.

Facility one is a residential aged care service operating outside a metropolitan area of South Australia and provides residential and community services to the local and broader community. Forty-three residents are accommodated. The private rooms have their own ensuite and the site has a dedicated dementia-specific unit for those with progressive dementia requirements. It was noted that residents with dementia in this setting were also located in some of the private rooms particularly if they were not deemed at risk of wandering. The facility was divided into wings with a centralised mall area that housed a coffee shop, craft area, hairdresser, general meeting area and space for families and residents to gather. Staff were seen to be engaged and involved in all aspects of resident care and welfare.

The facility also contained a further 72 rooms that historically housed individuals with less care needs in hostel type accommodation. This area applies an aging in place philosophy, and the residents mainly reside in their allocated room for the length of their stay. For many, a noted decrease in mobility and a corresponding increase in care requirements have evolved over time, usually without a corresponding increase in staffing support.

The residential care service is staffed by RNs, EENs and UHCWs. A nurse practitioner (NP) is consulted to assist with resident assessments, medical liaison, education and resident reviews should the RN seek further advice or clarity. The service also provides interim and palliative care arrangements in dedicated rooms in the facility.

5.5.2 Facility Two

A suburb of South Australia was the site for the second facility. This was the largest in bed numbers within the selected facilities. This facility caters for residents formally within high and low care classifications as well as offering respite services. There was a dedicated dementia-specific unit with an outlying secure garden for residents to enjoy. Although the building is aged in itself many modern features existed. A specially designed gym is available for residents with personal trainers and a physiotherapist on-site to assist and assess the resident’s physical ability and exercise requirements. The staff informed me that no-one is exempt from participation; it is only the degree of participation that varies between residents.

All rooms are single or couples rooms with attached ensuites. Residents are encouraged to make their room as homely as they like, and to become involved in the activities the facility has to offer. The interesting area in this facility was the dedicated space for entertainment. In this space residents have the opportunity to engage with youth, school and community groups over coffee, a game of pool or a social beverage at the end of the day. It is the socialisation of residents in this setting that was a standout point. Staffing exists in a comparative fashion to facility one with RNs, EENs, and UHCWs employed. Likewise, a NP is consulted to assist with resident assessments, medical liaison, education and resident reviews should the RN request these.

5.5.3 Facility Three

The context of the next organisation differed slightly. This organisation forms part of a faith-based philosophy and has values that espouse to equity and justice, and collaboration and participation of individuals at a point in time in their life where needs arise. As they operate multi-state facilities, their Board of Governance was aligned with a national strategic agenda driven from each of the State jurisdictions. This was a point of difference from the first facility where only a single state based Board existed.

The welfare of residents was achieved through a supported 'healthy aging' approach. The organisation valued and respected the individuals residing in their residential aged care settings and consumer led groups were included in local and national conversations. The organisation existed with a centralised board of governance, however maintained and encouraged participation and local governance within each of their domains whether that was community or residential services. The facility was led by a manager responsible for the operational management of the facility.

Located beachside in Southern Queensland and operated by a large not for profit organisation, facility three offers residential aged care services to the community through independent living units and aging in place through residential care services. The service also provides a specialised dementia-specific unit and short term respite.

The residential facility was arranged in six wings, each with its own dedicated lounge, dining room and kitchen. Two specifically designed wings provided residents with a 'dementia safe and secure area'. This area was designed for those residents who were deemed to be at risk of becoming lost if not within a secure area. The area layout was such that residents were able to wander, interact and enjoy a house-like environment without fear of becoming lost or unsafe. The environment was always busy with lots of activities in progress, outings being organised, notice boards being updated with the latest photographs and news. In many areas of the facility the rooms had views or opened out onto a garden.

Residents were encouraged to make their room their own with their own furniture, personal belongings and photos.

A large central area existed in the setting where weekly concerts and music sessions occurred, regular craft sessions were held, and where other activities were conducted. This area seemed to be a central meeting point for the residents, their families and visiting community members. The service employed a Lifestyle and Leisure Coordinator who worked with residents in activity planning and implementation. Activities appeared to be organised in conjunction with the residents, and the staff engaged in activities that enhanced resident mobility, promoted wellness and provided enjoyment.

The residential care service was staffed by RNs, EENs and UHCWs. Residents are housed within accommodation areas that follow the Australian Government classification of primarily high care, and a small number of low care and palliative care accommodation.

5.5.4 Facility Four

Facility four was situated in a regional city in South East Queensland and catered for city residents as well as residents from surrounding rural farming communities. Facility four was aligned with the broader organisation of a faith-based philosophy with values that espouse to equity and justice, and collaboration and participation of individuals at a point in time in their life where needs arise. The facility was focussed on aging in place. A secure dementia unit existed with views out to landscaped areas and courtyards. A Lifestyle Coordinator was employed to facilitate activities, outings, and recreational opportunities for all residents inclusive of some activities specifically geared toward the residents with dementia.

The rooms were contained in what was referred to as ‘houses’ within the complex. There was a variety of new and refurbished rooms some with private ensuites, others with ensuites shared with one other person. Each house area had its own open plan lounge and dining room. Activities occurred in these areas throughout the day. There were older areas in the complex alongside more modern systems such as areas with electronic monitoring and the ability to communicate electronically with family. The staffing mix was consistent with other facilities with

RNs, EENs and UHCWs employed. There was no NP employed in this facility. Staffing included pastoral care workers and qualified spiritual carers, many of these rostered volunteers.

5.5.5 Summary of Facilities

All four facilities appeared well organised, had stable facility managers in place, and represented staffing cohorts not dissimilar to those described in the Australian aged care research based literature (Bellis, 2010; Chenoweth et al., 2010; Dwyer, 2011; Ibrahim et al., 2014; Tuckett, Hughes et al., 2009; Tuckett et al., 2011; Venturato, 2007). The dominant workforce in all facilities was the UHCW. The EEN primarily was care lead in either the hostel settings or in the dementia-specific units. The RNs assumed the roles of care coordinators, supported by EENs and UHCWs during the day and as the sole RN after hours and on weekends. Two facilities had access to a NP who assessed residents and provided interventions as deemed necessary in collaboration with visiting medical practitioners.

Each facility was interested in being part of this research project with a willingness to engage and be involved. With a total of four facilities willing to participate and an acceptance from facility managers and organisational governances and ethics approval to proceed, the quest began to seek suitable participants to assist in answering the research question about the leadership role of the RN in residential aged care.

5.6 PARTICIPANT SELECTION PROCESS

It was determined that to suitably locate and attract staff that had a longstanding and solid understanding of working in the residential aged care setting the use of purposeful sampling would be best. Purposeful sampling is defined by Morse (1991, p. 129) as '... the process whereby the researcher selects participants according to the needs of the study'. Further to this Coyne (1997) elaborates that purposeful sampling enables the researcher to utilise their knowledge on a topic and use this knowledge to identify potential research participants.

The identification of suitable research participant groups was essential to the research given its qualitative nature and relatively small sample size. As the research sought to discover the 'what is' of the leadership role of the RN in residential aged care, it was essential to recruit participants who could provide rich information through their experiences and stories. Coyne (1997, p. 623) identifies that through the use of purposeful sampling the researcher is more likely to gain data that provides the avenue to '... learn a great deal about issues of central importance to the purpose of the research.' The use of purposeful sampling ensured that all participants had experience in the aged care setting and the ability to share their knowledge based on their experiences.

This enabled a choice of individuals based on their knowledge, experience and understanding of the leadership role of RNs in residential aged care settings. The purpose of the discussions did not surround individual staff personalities but rather knowledge, work experience, work hours, leave schedules and availability of staff.

5.6.1 Participant Selection

The selection of suitable participants required all staff regardless of their level of employment to be part of the full time staff working at one of the selected residential aged care facilities. They could be RNs, EENs, or UHCWs. Participant selection was developed for each of the staff groups interviewed. This provided the researcher with suitable clinical care staff for interview who had knowledge of the residential aged care organisation, its processes, and structure and had worked either with RNs or as an RN.

5.6.2 Introducing the RN

RNs needed to meet the following specific criteria:

- Hold current RN registration with the Australian Health Professional Regulation Authority (AHPRA),
- Be employed as an RN working in the direct resident care areas or,
- be employed in the position of Clinical Nurse (CN) or Nurse Practitioner (NP), Nurse Education or Quality and Risk Management in the facility, and

- have been employed at the aged care facility for a minimum of six (6) months.

The Scope of Practice and National Competency Standards for the role of an RN and NP are provided by the Nursing and Midwifery Board of Australia (NMBA, 2016b). This provides the RN and NP with the scope and defined domains of their practice (NMBA, 2016a).

5.6.3 Introducing the EEN

The second cohort of clinical care staff was the EEN. The EENs needed to meet the following specific criteria:

- Have satisfactorily completed a recognised enrolled nursing diploma course and be registered with AHPRA to practice as a medication EEN (Jacob et al., 2013; Milson-Hawke & Higgins, 2003; NMBA, 2016a).
- Be employed as an EEN and have been working at the aged care facility for a minimum of six (6) months.

The scope of practice pertaining to the role and functions of a registered EEN is provided within a national competency standard provided by the Nursing and Midwifery Board of Australia (NMBA, 2016a). This provides the EEN with the scope and defined domains of their practice (NMBA, 2016a).

5.6.4 Introducing the UHCW

The final participant cohort consisted of the UHCW. This group constituted the largest number of aged care workers in the residential facilities and were rostered in low care, high care and dementia-specific units. Although this research refers to the role as a UHCW, there are a number of synonyms that exist that refer to such positions in aged care facilities. These titles are inclusive of personal care worker, care worker or assistant in nursing. The title used in this research is that of unregulated health care worker (UHCW).

There are many and varied definitions of both the title and scope of the UHCW, from one that performs ancillary roles in health care to one that provides hands on care in the areas of showering and bathing, mobility, feeding and hydration,

toileting and general comfort related cares in a variety of settings (Barbosa et al., 2015; Duffield et al., 2014). In some settings this scope of practice extends to the administration of medications, to the recording of clinical observations, the completion of basic wound dressings, and the taking and recording of blood glucose levels. The role and scope of the UHCW was very much dependent on the requirements and practice demand in each setting. Understanding the role of the UHCW and their experience of the leadership role of the RN in aged care was important. It was their presence in the care team, their visibility in many and varied aspects of care and the understanding that as a group they constituted the largest cohort providing care (Dill & Cagle, 2010; Duffield et al., 2014).

The specific inclusion criteria for the UHCW were based on:

- Participants having completed a relevant certificate qualification in health care or its equivalent, and;
- having worked in the residential aged care organisation for a minimum of twelve 12 months.

With the inclusion criteria for the last cohort finalised, the acceptance of this criteria was reinforced with facility managers and the broader organisation via personal communications and ethics applications. Once an acceptance was achieved a call for participants commenced in each facility.

5.7 DATA COLLECTION

Data collection was about hearing staff stories, anecdotes and experiences of their everyday, their contributions and their understanding of the RN leadership role in their aged care work setting. The use of a semi structured yet an in-depth interview style provided the interviewer with the opportunity to hear the participants' stories as felt and understood by the clinical care staff. The method used was guided by a set of questions seeking to gain information with a focus on RN leadership in residential aged care. The questions were created following discussions with aged care health experts, and a review of the implications found in the literature review. The questions utilised in the data collection interviews are included in Appendix E. The essence was to capture in the participants' own words, their thoughts, perceptions, feelings and experiences (Liamputtong, 2013; Moules et al., 2015). In

some instances questions followed the guide outlined in Appendix E, in other instances the interview flowed and information was provided by the participant with little guidance from the questions provided.

The in-depth interview concept was interpreted by the researcher as a way of seeking the experiences of the phenomena of RN leadership in residential aged care through one on one discussion with staff working in the area. While the focus and questions were upheld in the interviews, time was also made available for some discussion on individual points.

The interviews were conducted at a time suitable to both facility requirements and staff availability and comfort. Participants were included in discussions surrounding a suitable time and place for the interviews. This resulted in interviews being conducted in the respective residential care facilities, away from the day to day routine of the setting. Interviews were conducted in a quiet area away from office staff, general routine and resident care areas at quieter times in the operation of the facility. One participant interview was conducted outside the facility at an agreed place and time.

The interviews commenced by gaining an understanding of the participant, their experiences and understanding of their role within the residential aged care setting. This set the scene for the interview, allayed any anxiety that may have been present and opened the discussion in relation to the leadership role of the RN in that setting. The use of follow-up questions enabled the participants to share more about their story. Probing was used as required to prompt participants to provide more detail on their experience so that clarity of understanding was able to be determined (Liamputtong, 2013; Streubert & Carpenter, 2011). At times, specific questioning was required to enable the researcher to understand the context of the words used by the participant. It was this type of questioning that enabled clarity of data to be assured. The researcher also found the use of a minimal amount of indirect questioning enabled the participant to think of their experiences from their own perspective and their thoughts. This questioning was used minimally, however it provided a sense of understanding relating to the participant's own attitude which otherwise would not have been known or articulated.

Hearing the experiences, processing the volumes of information, anecdotes and experiences obtained from each participant required the researcher to listen, hear the story in silence, probe only when necessary and to acknowledge, respect and respond to their interpretation of the world of the leadership role of the RN in residential aged care. It was not a time to lead the questioning, to ask why, but rather a time to listen, to hear what was said and importantly how it was said (Liamputtong, 2013; Moules et al., 2015).

5.7.1 Using In-Depth Interviewing

The data was about more than just one person, and was inclusive of the role of RNs rather than the leadership of one RN. The interview process aimed to gain an in-depth understanding of the experience as told by the participants of the leadership role in its entire context to them. The interviews included UHCWs, EENs and registered or clinical nurses from the selected residential aged care facilities. Table 6 identifies the breakdown of interviews by position and of the interview timeframe.

Table 6. Breakdown of participant interviews by position

Pseudonym	Identity No.	File Name	Audio length of time	File type	Role
RN 1	141	RN	40:13	WMA	RN
RN 5	145	RN (Nurse Practitioner)	1:18 24:02	WMA Mp3	RN
RN 8	148	RN	46:58	Mp3	RN
RN 9	149	RN	1:03:16	Mp3	RN
RN 10	410	RN	56:28	WMA	RN
EEN 3	143	Enrolled Nurse	34:11	Mp3	EN
EEN 4	144	Enrolled Nurse	38:15 25:22	Mp3 Mp3	EN
EEN 12	412	Enrolled Nurse	33.25	WMA	EN
EEN 13	413	Enrolled Nurse	44.18	WMA	EN
PCW 2	142	Personal Care Worker	28:36 18:12	Mp3 Mp3	PCW
PCW 11	411	Personal Care Worker	32.18	WMA	PCW
PCW 6	146	Personal Care Worker	35:27	Mp3	PCW
PCW 7	147	Personal Care Worker	26:23	Mp3	PCW

5.8 DATA ANALYSIS

Permission was obtained to audiotape the interviews and participants were provided with their interviews once transcribed for review and consent. All interviews were recorded using the Voice Pro recording app and saved as a WPS or MP3 file. Each of the audio recordings of the participant interviews was transcribed verbatim into written form for interpretation through the utilisation of the phenomenological structure. On completion of the interview, participants were re-informed that the recorded interview would be transcribed verbatim to text and returned to them for checking of accuracy. The written form was inclusive of pauses, laughter and other expressions.

Member checking or participant validation is according to Liamputtong (2013, p. 32), '…the single most crucial technique for establishing credibility, and is the process where the researcher seeks clarification from research participants'. At this stage, participants were provided with the opportunity to confirm the information in their transcript to ensure the quality of the data collected portrayed the information that the participant intended. Participants were asked to read their transcript in which they participated and to check the accuracy of the data. This accuracy was based on whether the participants considered that their choice of words matched what they actually intended. Participants to articulate areas in their interview that they felt required greater explanation. The opportunity existed to add further reflections that the participants deemed relevant to the research either through a written reflection or as an additional taped interview. Four participants chose to provide further information. Three of these participants provided information via a recorded teleconference and the fourth through a written reflection. Member checked transcripts were signed by participants as accurate and returned to the researcher. If participants were content with the transcript they did not need to provide any further information to the researcher.

Once all of the data were collected the data analysis process, and the hermeneutic cycle of interpretation of the narrative began. Naive reading involved the reading of the transcripts several times to gain an understanding of the whole text and its meaning (Lincoln & Guba, 1985; Salmela et al., 2012). The stage by stage process of analysis involved listening to the recordings many times over, reading the

transcripts whilst listening to the interviews, reviewing each question and the subsequent participant responses. Analysis of the data and further knowledge were gained through a deeper structural analytical process that followed this initial naive reading stage.

The initial stage of data analysis familiarised the researcher with the content of the transcripts and identified concepts that emerged from the participants. The term concept was used to describe the initial findings that emerged from the transcripts. The initial concepts were determined for each participant group of the UHCW, EEN and the RN. The analysis through naive reading resulted in concepts that arose from the narratives which guided the second stage of analysis.

The second stage of analysis involved the collection of like concepts into like groups. The 'like groups' became known as sub categories. The sub categories were defined as the more collective expression of the concepts originally found in the naïve reading initial stage of analysis. This second stage of analysis provided the researcher with a more distinct idea of the emerging sub categories that arose.

The concepts were linked with sub categories and the final two overarching categories that defined the leadership role of the RN. It was important that the identified categories aligned with their subcategories and these were related back to the initial concepts extracted. This process enabled the meanings to emerge and the voice of staff to be heard. The writing of this phase has been completed in steps from the emergence of initial concepts, through the descriptive phase and in the outcome and discussion of the interpretations found. The emerging concepts are discussed in Chapter 7. The further analysis and collective grouping of the concepts is seen in Chapter 8 section 8.3 and Chapter 9 section 9.2 where the subcategories of what emerged in the leadership role of the RN are outlined. The final emergence of two key categories that define the leadership role of the RN are provided.

The concepts derived from the reading phase were collated into four sub-categories, one from the each of the RNs, the EENs, the UHCWs and a final category that combined all groups in a collective form. It was the individual groups and collective synopsis that provided the baseline for the next phase of data analysis,

aptly referred to within the realms of phenomenology as structural analysis (Lincoln & Guba, 1985; Moules et al., 2015; Salmon, 2012).

Structural analysis in this research referred to what the text was really saying and was focused on detail (Foehl, 2014; Moules et al., 2015; Salmon, 2012). Within this analysis, a determination of what the text was saying was elicited and meanings or areas of understanding generated from the data. The generation of meanings again was considered and analysed in the context of each individual participant group and again collectively in a combined approach. The analysis of data occurred through an objective as possible examination of the text and its defined meanings (Liamputtong, 2013). The condensed meanings were further read and reflected upon with regard to the background of the naive understanding, and in relation to any similarities or differences. The themes or meanings that emerged distinctively had the feel, expression and understanding that the participants expressed in the interview process, and now grouped to reflect the lived experiences of the participants collectively. The process was required to be repeated until the naive understanding was validated and various meanings detected (Moules et al., 2015; Salmon, 2012).

Corroboration was managed through the use of NVIVO© Software (QSR International, 2016). The use of NVIVO© was not intended to replace the manual analysis and themes found in the data, but aimed '... to further increase the effectiveness and efficiency of the manual analysis' (Bazeley, 2013, p. 2). The software NVIVO©, allowed for the greater efficiency of managing data (Bazeley, 2013). NVIVO© was utilised to corroborate trends and cross examine information obtained through the interviews.

From the analysis and resultant emergent meanings that appeared, phase six of the research began. This was inclusive of the key meanings or themes identified through the literature and the research findings. The experience as outlined by the RN, EEN and UHCW were individually and collectively articulated, defined and discussed. Through a detailed analysis of data obtained from participants, and a comparative analysis of the literature the discovery of the essence, the 'what is' of the leadership role of the RN was revealed.

5.9 CHAPTER SUMMARY

This chapter has outlined the method deployed to reveal the essence of the RN leadership role in the residential aged care setting in Australia. The facilities utilised have been introduced, the participant selection process defined and the data collection strategies discussed along with an outline of the data analysis process has been provided. The ethical considerations and processes for ethical approval have been discussed.

This chapter has provided the base, the starting point. The next stage takes the reader within the data, describes the participants and their role and then shares the beginning of their story, their moment in time in sharing the leadership role of the registered nurse in residential aged care.

Chapter 6: Introducing the Participants

6.1 INTRODUCTION

Chapter six explores each of the participant groups and individually introduces the participants to the reader. The participants in this instance, the UHCWs, the EENs and the RNs form the family of voices that construct the narrative of the research. Section 6.2 introduces the UHCW through the analogy of the string family. Section 6.3 introduces the EEN as a member of the percussion family. The registered nurse is introduced in section 6.4 through the analogy of the woodwind section of an orchestra.

6.2 THE STRING FAMILY – THE UHCW

The first participants, the UHCWs assimilate with the string family who are the largest and most diverse group of the orchestra. Understanding the role of the UHCWs and hearing their voices whilst working with the RN was a must. The interview process enabled four (4) UHCWs to share their story. Each story had a different beginning and brought a sense of personal reality to the experience of working with the RNs in residential aged care settings. The comparison of the role of the UHCW with that of the violin in an orchestra was relevant. The violin, the most visual instrument in the orchestra, has the role of carrying the melody and providing the foundation to the music.

The UHCW provides the foundation of care to the residents in the residential aged care setting. This foundation is inclusive of personal care, hygiene, nutrition and hydration needs provided to an individual (Duffield et al., 2014). The activities and skills required are in the form of support with feeding and hydration, activities relating to mobility, movement and access, toileting, hygiene needs and social care, and activities to promote social interaction and engagement (COAG, 2015; Duffield et al., 2014). The UHCW is not registered with any regulatory authority and their scope and role differs by organisation, differs by state, and differs by name and context depending on who, or what, is accountable for their practice (COAG, 2015;

Duffield et al., 2014). The one element that remained stable in all facilities was the notion that the UHCW comprised the largest presence in the aged care workforce.

Three (3) female and one (1) male UHCW participated in the interviews. In introducing the participant group it was recognised that between the participants a total of over twenty-three years' UHCW experience was noted. This provided a rich source of information that was able to be shared and analysed in the context of the leadership role of the RN in residential aged care. All participants held a Certificate III in Aged Care, Disabilities and Community Care. One (1) participant was a RN from an overseas country where the nursing education and registration was not recognised by the Nursing and Midwifery Board of Australia. One (1) participant held a Certificate IV in Leisure and Health in addition to their baseline Certificate III qualification. Future career aspirations were voiced by one (1) participant, with the remaining three (3) participants expressing their happiness with their current role. A synopsis of the time spent by these participants in the aged care sector and their qualifications is provided in Table 7.

Table 7: Summary of participant information – unregulated health care worker

Time worked in aged care	**Gender**	**Qualifications**	**Future plans**
7 years	Male	Cert. III in Aged Care, Disabilities and Community Care	Continue working in the area
2 years	Female	Cert. III in Aged Care, Disabilities and Community Care Current Certificate IV Leisure and Health	Seek to become a diversional therapist
11 years	Female	Cert. III in Aged Care	Continue working in the area
2 years + 18 months agency	Female	Overseas RN, Cert. III in Aged Care	Continue working in the area

Each UHCW shared their story of coming into the aged care industry and what this meant to them personally as a work choice. As each participant had their own reasoning and rationales, it was important to hear their story as the first step in understanding the 'what is' of the RN leadership role in residential aged care.

6.2.1 UHCW Participant One

The first participant outlined his move from a position within retail to one of caring for people as they aged and came to live in residential aged care. It was what he described as a move to caring, and one of providing care. A shift in career choice to what he *"... always wanted to do. My theory is that we always take so much from society and never give back. So, it's a good opportunity to be able to give back*." What transpired as a desire to move vocations is now a seven-year venture of caring and working in a team to provide both the physical, emotional and social care needs to residents.

This participant described his role as being *"... the personal care of our residents and everything that goes with that. From medication ... general wellbeing, entertainment, caring."* The role he described was about caring. Inclusive to this was the physical, emotional and the social well-being of the residents, and their families.

6.2.2 UHCW Participant Two

This participant had worked in the aged care setting for the past two (2) years where her work as an UHCW led to a portfolio now inclusive of the activities coordinator role. Having previously worked as an events manager, the role of UHCW and activities coordinator came to her quite naturally. The one area she proclaimed as difficult to adjust to, was the notion of shift work and juggling children and work life. This participant explained she's *"...always had an interest in aged care."* She *"...started doing a Cert. III whilst the kids were at home and I came here, started volunteering as an activities assistant."* It was from here that the participant outlined her role and how this further assisted in the care of residents, particularly their social care needs. It is a role that requires frequent communication with the RN, providing updates on mobility, dexterity and the changes to the mental capacity of residents. This participant described her role as

> "...organising activities for the residents and looking after their recreation and lifestyle needs. …making sure they've got enough clothes, giving them things to do, making sure that they've got everything they need, are still involved in the community where they want to be."

This participant expressed the desire to care, and the willingness to want to look after others. For this participant the role described was quite extensive and across many areas of both clinical and social care requirements.

6.2.3 UHCW Participant Three

Participant three had a different story. It was that of a registered nurse from an overseas country where the nursing education was not recognised as equivalent to requirements for Australian registration as an RN. This worker's story was one of care, the passion to care and the desire to help others. The participant shared her story:

> "I have worked in health before, not here, but in health. I was a nurse in my country, some time ago….my family came to Australia and I looked for work. I cannot do my nursing here, without going back to study again…so I work here. I love the people I care for, they are so grateful, the place is nice and the staff are good."

Her story was not dissimilar to the story shared by the first participant with the provision of care the primary focus of their roles. She described the landscape as one where a resident may become unwell, unsteady on their feet, confused or lethargic very quickly and she saw this as her role to not only recognise the situation, but to also report it.

6.2.4 UHCW Participant Four

The final UHCW described herself as an experienced carer. Her previous career saw her as a secretary with time out of the workforce to be with her children. It was as the children grew that she embarked on a new journey as a care provider in a local residential aged care setting. Her eldest daughter provided the inspiration, and also the drive for this entry back into the workforce. Her daughter, having entered into the aged care workforce herself and completed a Certificate III in Aged Care, was an inspiration to her mother. As the participant reflected:

> "I enjoyed the idea of a sort of caring role but not as a nurse. So I virtually followed in her footsteps. She did her Certificate III and got aged care work and soon after I did exactly the same."

With eleven (11) years' experience, this participant has seen the diversity of change both within the residents she cares for, and in the mode of operation of the facility.

This synopsis of the UHCW participants has introduced one group of workers in the residential aged care industry. No orchestra is complete with one set of instruments alone. To gain insight and further perspectives on the 'what is' of the leadership role of the RN in the setting the voices of the EENs and the RNs also needed to be heard.

6.3 THE PERCUSSIONISTS – THE EEN

'The staves for the percussion instruments are massed in the middle of the score' (Stewart, 1989, p. 107). The middle is the place that the EEN knows well as they balance their role within the residential aged care team. In this instance the middle is described as being nestled between the roles of the RN and the UHCW. For this reason the analogy of the percussion family is appropriate. It is the EEN that assumes the responsibility of leadership alongside the direction of the RN. The EEN leadership was seen in positions of care coordinator in hostels and dementia units. EEN leadership was also seen in the delivery of care and in the coordination of UHCWs in the day to day operation of facilities.

The EEN research participant group consisted of four (4) EENs. Each had their own story with three (3) participants commencing their employment as UHCWs and in time, transitioning through ongoing education to the role of EEN. Understanding this participant group further was achieved by listening to their story of how and why they entered the aged care setting. Table 8 identifies the time each participant has worked within the sector and their respective qualifications. A breadth of cumulative knowledge and skill was apparent, with over fifty (50) years of collective experience noted.

Table 8: Summary of participant information – EEN

Time worked in aged care	Gender	Qualifications
15 years in Aged Care PC for 4 years EEN for 11 years	Female	Assistant in Nursing, Certificate III Aged and Disability Services Diploma of Nursing (EEN)
8 years as an EEN	Female	Diploma of Nursing (EEN)
From PC to EEN 13 years an EEN	Female	Assistant in Nursing, Certificate III Aged and Disability Services Diploma of Nursing (EEN)
From PC to EEN PC for 8 years EEN for 2 years	Female	Assistant in Nursing, Certificate III Aged and Disability Services Diploma of Nursing (EEN)

6.3.1 EEN Participant One

For participant one the journey began at the age of sixteen (16), in England. As a young girl she wasn't sure what job she wanted but was interested in the concept of nursing. She started work as an Assistant in Nursing (AIN) and *"... then I did extra study and ended up as an EEN when the government were giving out all the scholarships to aged care facilities."* As an EEN this participant saw her role as care provider and overseer of the UHCW. She explained *"... it is a big role but the residents are here because they're not able to look after themselves."* Participant one spoke of the greater medical need of residents, the changes in care requirements and the greater focus on palliative care and chronic illness management. She also described the need to supervise the UHCW, to work with them and guide them.

6.3.2 EEN Participant Two

The next participant was an EEN with thirteen (13) years' experience in the one aged care facility. She had commenced her career as a carer and progressed into completing the diploma of enrolled nursing. This EEN coordinates the hostel area of the setting she works in.

> "I've basically worked all over the complex under the different RNs that have been here as long as I have. Down in the hostel though it's really changed a lot down there, stability is one thing I have to deal with or the lack of stability of the RN down there, yeah."

This participant was very familiar with the routine and ritual in the hostel area. The participant saw this as an important aspect of her role. She seriously

considered the needs of the residents she cared for and saw her role as the liaison between the RN and her role as EEN. She spoke fondly of the residents and the relationships she had developed with them over her time working in the hostel environment. She outlined her reasons for working in the setting and spoke highly of the need to be responsive and caring in the work that was completed.

6.3.3 EEN Participant Three

Participant three is an eight (8) year veteran of residential aged care nursing. With no prior experience and a desire to care for others, the participant completed the diploma of nursing and commenced work in the acute care hospital setting. It was in this setting that the reality of not being able to get to know those she cared for over any real length of time became apparent and so she entered into the residential aged care setting. It was this EEN that discussed the change in the type of resident that is seen in the facility, a change she has noted in her eight (8) years in the role. For this EEN it was about the people, their relations and the care that was provided.

6.3.4 EEN Participant Four

This same passion and drive was seen in the final EEN interviewed. She was keen and motivated to share her story. For this participant the shift from that of UHCW to one of an EEN has seen the shift in responsibility and now the desire to do even more. It was interesting to hear her story as she now coordinates the care within the hostel environment. *"I look after all the staff and residents within the hostel area. That's my role."* Participant four described that it is the knowledge that each level of staff has that enables them to do, to know, and to provide the whole range of cares required to a resident. The EENs provided their synopsis, their experience of working in aged care and with RNs. They identified clearly that their role was concerned with the practical side of care provision.

6.4 THE WOODWIND SECTION - THE REGISTERED NURSE

A total of five (5) RN participants were included in the research. Each of the participants came with their own story, each different to the next and with their own perspective of what the RN leadership role entailed. A cumulative figure of greater than 100 years' experience is seen from within the RN cohort. Table 9 outlines the synopsis of the RN participant group the amount of time worked within the residential aged care setting, the gender of the participant and the qualifications held.

Table 9: Summary of participant information – RN

Time worked in aged care	Gender	Qualifications
15 years	Female	Certificate in Nursing, Bachelor in Aged Care, JBI Research Fellow graduate Current role as assistant site manager RN Previous roles - clinical nurse consultant Hostel registered clinical nurse 7 years Multiple facilities
20 plus years	Female	Certificate in Nursing, Bachelor of Nursing, Master of Clinical Nursing (Nurse Practitioner)
39 years	Female	RN, Bachelor of Nursing
15 years	Female	RN (Certificate in Nursing), Grad. Dip. Palliative Care and Aged Care
21 years 2½ years aged care	Female	RN (Certificate in Nursing)

The diversity of experience and the accumulated wealth of knowledge attained from each of the RN participants was shared in the quest to further define the 'what is' of the leadership role they held.

6.4.1 RN Participant One

In her introduction the first RN participant spoke openly of the time when she commenced working in the residential aged care sector:

> "…if I think back to when I first started in aged care, so about 15 years ago and being a CN probably about 13 years ago; I just think the complexities of like the residents coming in to aged care now. It's much more demanding."

The enormity of the role appeared no problem to this RN, an experienced professional. The participant highlighted that it was not often that the chance to be heard or to discuss the role as they see it and live it occurs. Mostly, the role was

about doing, completing the work and planning for the next shift, the next improvement or the next admission or discharge.

6.4.2 RN Participant Two

The next participant shared a different story. She recounted the story of commencing in the residential aged care setting as a young nursing graduate then leaving and returning some years later with what she called *"wider wisdom and maturity"*. It is now that this participant fully recognises the efforts, challenges and achievements in the realms of aged care nursing and currently holds the position of Nurse Practitioner in the organisation. As a senior practitioner she guides, assesses and implements care direction for the UHCWs, the EENs and the RNs across a number of residential aged care facilities in the broader organisation.

6.4.3 RN Participant Three

The next RN participant's background in residential aged care and in rehabilitation and interim care was extensive both internationally and in Australia. It was the wisdom of this mature participant that extended to greater than thirty-nine years (39) and involved a range of roles from RN, nurse manager, nurse unit manager of a rehabilitation unit, and community liaison roles. Her breadth of experience was vast and listening to her story of that experience inspiring. The participant also shared the area she enjoyed most was that of education and the fundamental role education has in supporting staff as they support residents and families through a palliation journey. She spoke of how education and support provides the guidance to deliver care and provides the security to staff to know the right thing is being done.

6.4.4 RN Participant Four

Commencing work as a RN in a medical unit, participant four then moved into roles in the residential aged care setting. This is the area she has remained in and has focussed her further education on caring for those requiring palliative care. This RN has also completed further education and training in caring for those with dementia and sees her role as one of educating staff. The diversity of aged care

experience over a fifteen (15) year time span allowed this RN to reflect on the changes in the setting during this time.

6.4.5 RN Participant Five

With greater than twenty-one (21) years' experience as a RN and only two and a half of these in the aged care setting, participant five offered a different perspective to those who had worked in the sector for longer periods of time. It was this perspective of working within the constraints of regulation, the supervision of vast numbers of residents and the coordination of care where the predominant worker was an UHCW that was of interest. She shared the story of working in a setting that tried hard to meet the needs of residents in a resource-depleted system that made amends and band aids for the fiscal decisions that were required.

6.5 CHAPTER SUMMARY

This chapter has introduced the individual backgrounds of each group of participants using the analogy of members of an orchestra. The participants, the UHCWs, the EENs and the RNs individually perform each shift yet collectively provide the residential care in its more holistic and true sense. These introductions have provided the foundation for the interviews and the establishment of the nursing family in the residential aged care setting.

Chapter 7: The Description of Leadership

'A conversation of sounds melting constantly into rhythm. A shell waiting for you to listen'.
Rich (1971, p. 53)

7.1 INTRODUCTION

The rhythm of the music is akin to hearing the descriptive narratives of the clinical care staff discussing their perceptions of the leadership role of the RN in the residential aged care setting. Hearing the voices of the clinical care staff provided the opportunity to hear the complexities, the positives and the challenges that were faced in the day to day RN leadership role enacted. Through the perspectives shared by the UHCW, the EEN and the RN, the discovery of the 'what is' of the leadership role began. The metaphoric analysis in this chapter likened the role of the RN as not unlike coordinating the rhythm of the music.

The initial phase of analysis commenced with a review of the descriptive narratives. The chapter firstly unveils a collection of descriptive anecdotes from each of the clinical care staff cohorts. Section 7.2 shares the descriptions provided by the UHCW and section 7.3 the EEN and section 7.4 from the RN. The descriptive synopsis of the key areas that each cohort determined as important aspects in the 'what is' of the leadership role of the RN in residential aged care are presented. All three cohorts of staff spoke of the changing face of the residential aged care workplace, and descriptions from the staff participants are shared in section 7.5. Section 7.6 of the chapter shares a collective synopsis of the descriptive components voiced by the UHCW, EEN and RN. It is through the analysis of this collective synopsis that the transformation of the written narrative into meanings commences. There were many anecdotes heard and from these a number of key concepts were recognised. These concepts are shared through the descriptive anecdotes and the beginning analysis from each of the clinical care staff cohorts. The first cohort is the UHCW.

7.2 THE DESCRIPTIVE NARRATIVE OF THE UHCW

Regulation of the unregulated health care workforce has remained the responsibility of individual organisations through both position description, policy and human resource practice (COAG, 2015). UHCWs working in the area are able to articulate clearly and extensively on the changes to their practice over the past decade. Each UHCW participant had their own unique story of why they work in residential aged care and how they became involved in caring for the aged. All four (4) UHCW participants shared their experience of working in a team with different RNs. The interviews commenced with an understanding of their individual backgrounds, their career aspirations, and their words in defining the RN leadership role in residential aged care. The descriptions provided direction and understanding of both the role of the UHCW and the leadership role of the RNs they worked with. The role of the UHCW was described as one of caring. Inclusive to this was the physical, emotional and social well-being of the residents and their families. The UHCWs also described their role as one that communicated frequently with the RN, providing updates on mobility, dexterity and the changes to the mental capacity and the health of residents. These were important aspects to know in understanding how the clinical care staff saw their role individually, and also as a part of the team.

To share this information and the perceptions that were gained from the UHCWs specific quotes have been sourced in the first phase of analysis that capture staff perceptions of the leadership role of the RN. The quotes collected at the time of the initial stages of analysis were important sources in the data reduction phase that resulted in the emergence of initial concepts in the research. The quotes provided have been done so without attribution to an individual or facility. These share the perceptions directly from the role and the descriptions provided by the UHCW participants.

The UHCW's described their role as:

> "…the personal care of our residents and everything that goes with that. From medication … general wellbeing, entertainment, caring. You don't really think about it, … you just automatically deal with these things as they are."

> "Organising activities for the residents and looking after their recreation and lifestyle needs."

> "…making sure they've got enough clothes, giving them things to do, making sure that they've got everything they need, are still involved in the community where they want to be…"

> "…putting in place any interventions to curb behaviours within our dementia diagnosed residents."

> "…starting at 6.30am with breakfast, getting residents ready for meals, and helping with feeding and tidying up."
> "… our normal every day is about care. It's what we know, what to do, and we will carry on."

The initial introductions from the UHCWs shared their perceptions of the role they undertake in the day to day work in residential aged care. Their experiences also identified anecdotes of working with the RN, the leadership displayed by RNs and the characteristics of the work environment that in their perception affects the leadership role seen, heard and enacted through the role of the RN. The perspectives of the UHCW's identified the experience of working together in a team with the RN. These anecdotes described:

> "I find it best when they [the RN] involve us and get our input on things, because basically, we're the ones that are dealing with the residents every day."

> "We can give them feedback and ideas on what we think would work…- they ultimately make the decisions and things…, I like it where we can give them a bit of feedback and have input as well."

> "I know they watch what we are doing, do lots and lots of paperwork, find out information for us to work better, ring and talk with the doctors, families, physio and anyone else that is required."

> “…we all know each other and the way that the rosters are structured you tend to work with similar people on a regular basis, so you get to know their quirks and how they think and work.”

> “You automatically just flow with your work without having to question things all the time. Unless there is something that's obscure but not right, I find the RN.”

> “If there’s any query, if we’re concerned about any problem with the resident, we will immediately go to the nurse [RN] and ask her, does she want to come and check or if we’re concerned in some way and she will follow that up for us.”

> “RNs will step in there and offer support or suggestions but it still falls on you to still get all these other things done.”

The RN leadership identified from the voices of the UHCW staff was based on the integrity and reliance of the RNs along with the knowledge, the ‘know how’ and the ability to coordinate, empathise and assist the team in care provision and the coordination of each shift. The anecdotes also outlined the autonomy that staff had in the individual role they held in the team. This autonomy was a feature that provided the UHCWs with the ability to complete the role of caring for residents. This insight provided the initial step in unfolding key concepts that became apparent in the initial and structural analysis of the narratives. The anecdotes captured the perception of autonomy as an important attribute.

The perceptions gathered a sense of a decision maker in the role of the RN and secondly a level of reliance, and dependability. Concepts emerged relating to the influence of care and care decision making that the RN enacted. The UHCWs each portrayed these concepts relating to the RN through the anecdotes provided:

> “... they have lots of knowledge, amazing skills, and are caring to residents. …. they do the accreditation stuff, you know all the standards we need to meet.”

> "I trust their judgement and follow their guide, she [the RN] will give us sort of specific directions on a particular need for that resident."

> "I do all morning shifts. So when we come on, although there is a sort of written hand over which will give you some very, very basic information about what's happened overnight, the RN will let you know if there's something specific."

> "If she wants to check dressings, if perhaps we need to get a urinalysis or something like that. She will give us sort of specific directions on a particular need for that resident."

The descriptive narratives shared a sense of purpose in the role of the RN. A role where terminology like *trust, amazing skills and knowledge*, *concerned about*, *go to the nurse*, *come and check*, *provide direction*, *have knowledge*, *skills* and *will follow-up* were common concepts. It was in this beginning analysis that the notion of *caring* was evident however also the *go to person*, the *trusting one, has the knowledge and capacity,* and the *one who makes decisions* had a strong presence.

The narratives of the UHCWs outlined specific anecdotes relating to working directly with the RN. One UHCW collectively spoke of a situation where the concept of trust, decision making and a presence appeared however the anecdote also shared the concept of working together, a team approach and learning from each other:

> "I cared for this lady with a terrible scratch on her leg, it was red one day and just did not look right, I rang the RN and she said she would look at it. When she came to our area, she found me and we both looked at it. It was good, I learnt more and she was able to get a plan in place to stop any further problem."

This was not a solo story as each of the UHCWs shared different aspects of working with the RN. The RN became the cornerstone in the communication of information each shift, and from shift to shift. The anecdotes shared by the UHCWs described the RNs role in communication as:

> "She [the RN] made sure that everyone knew about why I was doing it, explained to them, and then also even made sure it was in handover for the next shift what was happening, and continued that on for the next week."

> "…my duty is to read handover and to add to the EEN or RN notes and the RN will use my notes to add anything further if needed. Sometimes she asks, sometimes it doesn't get included it just depends."

> "I find it best when they involve us and get our input on things, because basically, we're the ones that are dealing with the residents every day."

> "We can give them feedback and ideas on care – they ultimately make the decisions and things… I like where we can give them a bit of feedback and have input on that as well."

> "…communication is never easy, we have an EEN and RN diary and a handover but sometimes things get missed."

> "I work in high care, and just need to know what has changed here…we get to know the resident so it is just if they are not well really…but the RN does all areas, they may not know what is happening specifically in our area unless we tell her. This is hard."

> "I'd contact the RN if I'm unsure about anything – and it's anything in – not in my scope of practice. I will always contact the RN."

These anecdotes identified concepts in the leadership role of the RN. The concept of providing information to the RN was noted. Importantly the timeliness of the communication was described as a time when a decision was required, or when an anomaly from the 'normal' had occurred in the care or condition of a resident. The desire to seek feedback was clear and the noted inclusion in the decision making process was evident.

Difficulties were expressed in the final narrative of making contact *when unsure* as this narrative was suggestive of a leadership role that was required when staff were unsure rather than a collective proactive approach to care planning. The anecdote was inclusive of accountability, decision making, influence and mentorship in the team, and also was suggestive of a level of autonomy from individual staff in the roles they completed.

> "I'd contact the RN if I'm unsure about anything [otherwise] - and it's anything in - not in my scope of practice. I will always contact the RN."

> So she [RN] relies on us a great deal to report to her and she will report to us if she's concerned. She's always there, it's just knowing when to contact her. There's always a nurse there to refer to if there is anything we need to query"

> "I would notify an RN or if you're doing medication and you notice differences in swallowing or refusal or anything like that. I would notify. I don't have any problem notifying an RN if I need to. That's just covering my butt as well."

The collective concepts that appeared in the initial analysis were not all of a positive nature. Descriptions provided by the UHCWs also discussed the complexities of working in the team and with the RN that assumed the role as care coordinator. There was acknowledgment in the narratives that each person worked differently and that not all staff would engage with each other in a positive and

transparent manner. The UHCWs saw areas of conflict and team dynamic with specific reference to:

> "On care decisions…. It changes depending on who you are working with, some [RNs] are good to work with, others leave you be and some want to know everything that is happening….that's what makes it hard."

> "There's a couple of RNs, me, personally, I just follow their decision-making. To me they're – it's more of a power play than residential care type of thing. So, yes, I just tend to follow direction."

> "…isolate us if we don't work the way they want us to."

> "I find is important, that they need to be there to be able to give the specialised care and the more higher needs care."

These excerpts provided an example of the complex team environment the RN coordinated. There was a sense in the transcripts that the RN was the accountable entity. The initial review of the narratives also highlighted the individual personalities of staff, and the nuances that existed. This aligned with the discussion surrounding power and organisational behaviour that Kanter (1977) describes. This sense of power was seen in the different approaches by different RNs and the response from the clinical care staff as to which style was preferable to them as either a personal choice or team beneficiary. The UHCWs further elaborated the construct of power with:

> "There're a couple of RNs, me, personally, I just follow their decision-making. To me they're – it's more of a power play than residential care type of thing. So, yes, I just tend to follow direction and watch my Ps and Qs depending on who it is."

> "I think perhaps if we're talking about if there's been a staff, you know, between staff issue, I think the nurse will then talk individually to each of the staff members and try and sort of talk with them and find out what the problem is and come to a compromise or an arrangement that, yeah, can work with everybody."

> "There is also about staff, sometimes people work with the wrong attitude, you know …some people just don't want to work here but do because they have no other work. I shouldn't say but it is what I see…sometimes their attitude is not good….that makes working really hard and others have to pick up. I care for my residents and love what I do; we need more people like that….you know….the work is not easy."

Professional attitude and approach along with the need for communication, and the ability of the RN to act as an intermediary source when workplace conflict became evident. In many respects the team nuances described spoke of the reality of human nature. In some instances it appeared that personal work attitudes or individual personalities existed. Discussions were noted amongst staff where in some instances a preference existed to which particular team member they preferred to work with. In other anecdotes the need to work rather than the want to work in aged care became apparent. This want to work aligning with the approach the RN leader had on influencing the team. These personal versus professional attitudes added further complexity to the leadership role of the RN and its impact on the team. One UHCW described:

> "You can see some nurses [RN] are here for the residents. They want to care for the residents and they're really person-focused, whereas others are just like, oh, I'm just here to finish my shift and get my pay cheque at the end of the week."

The need to feel a sense of belonging in the team was apparent from the UHCWs. The need to feel that the RN was working for the good of the staff and the resident was important. Team dynamics and the sense of belonging was an important concept that arose. This sense of belonging linked to the concept of

respecting individual autonomy in the workplace and also acknowledging the capacity of the role staff held.

> "…In some of the places I did agency they just bossed and told us what to do when it was more a list of ticking off the job, not really caring….you know."

> "I find it best when they involve us and get our input on things, because basically, we're the ones that are dealing with the residents every day."

The UHCWs outlined their need to be engaged in care, and resident decision making. The UHCWs expressed a desire to understand resident health conditions. The UHCW expressed the complexity that was seen in the conditions that residents were diagnosed. The names and care requirements of these were placed in an unknown territory, as UHCWs expressed their limitations in knowledge of what exactly the care requirements entailed in relation to a residents condition. This highlighted the complexities that the RN's experienced, particularly with reference to communication and care coordination each shift. The UHCWs noted:

> "I enjoy doing the medication, I find the medication very challenging… I still deal with that, I try and get my head around that. Once again, depending on the RN, you might get one RN that will only make one person medicate the facility."

> "Just a lot of communication as to where they sit and their medical standpoint, and then me then adapting what I've been doing with them."

> "…we sort of know the basic ground rules but we need to just check with the nurse and see if she's happy with that."

> "My biggest challenge is with medication, it used to be with the EEN or RN but now we do some too. That scares me, I have done training but I do not

> know a lot about them, family ask lots of questions and I don't know or have to find the RN to get answer. I hope that I give it all right all the time."

> "Our resident is on many tablets, the chemist put them in packs for most people so we give to the resident when they are due."

> "She's [RN] always there. There's always a nurse there to refer to if there is anything we need to query."

Recent changes to the scope of practice of the UHCWs included medication administration and resident vital sign monitoring in the daily care routines. The ability to complete these skills was recognised by the RNs and the UHCWs as an approach and application to the education program the settings provided. This program was organised and facilitated through the role of the RN. The complexity continued with the accountability and understanding of the reasons, rationales and outcomes of skills provided in the day to day care of a resident. The ability to respond to changes in a resident's health status still remained within the accountability of the leadership role of the RN.

7.2.1 Concepts arising from the role of the UHCW

Many different concepts have been discussed by the UHCWs working with the RN as leader in a team in residential aged care settings. The concepts identified highlight the complexity in the role as well as various different aspects that the RN is required to complete, understand or be able to navigate in their leadership role.

These concepts have been identified in areas of teamwork and working with people, the influence of the RN in leading the team, the importance of communication and the complexities that arose. In seeking to define the leadership role of the RN in the residential aged care setting what initially appeared was a myriad of concepts that needed to be coordinated, assessed and enacted, usually in tight timeframes by the RN. The need to set the tempo, and lead care decisions in knowing what was needed, where and how to appropriately and confidently respond became apparent in the initial descriptive analysis of the leadership role of the RN as

expressed by UHCWs. It was in this sense that key concepts started to appear. The first concept related to the need to know the aged care setting, its nuances and the staff, and secondly the ability of the RN to respond and to be able to apply clinical knowledge and practice, professional attributes of respect, understanding, mediation and education in the setting.

The key concepts arising from the introduction of the UHCW participants outlined an RN leadership role that was inclusive of a number of key concepts. These can be seen in Figure 1 as:

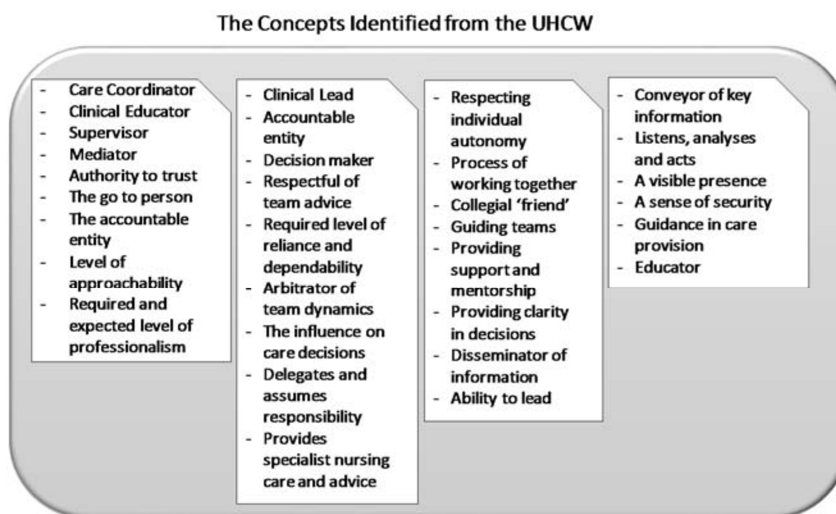


Figure 1. Leadership concepts arising from the UHCW

7.3 THE DESCRIPTIVE NARRATIVE OF THE EEN

To gain insight and further perspectives on the 'what is' of the leadership role of the RN in the residential aged care setting the anecdotes of the EENs and the RNs needed to be shared. The EENs provided many narratives, many of which connected with the concepts emerging from the narratives of the UHCWs. As in the UHCW analysis of the quotes provided have been done so without attribution to an individual or facility.

The EENs shared several new concepts in the leadership role of the RN that provided greater insight into the role and the ability of the team to work together. The leadership role seen by the EENs differed slightly in context to the UHCW. It was the EENs that assumed the responsibility of leadership alongside the direction of the RN. The EEN leadership was seen in positions of care coordinator within hostels

and dementia units, where support was provided from the RNs either remotely or following a direct request.

The EENs described their role as:

> "It is a big role but the residents are here because they're not able to look after themselves, so it's our job to make sure that they are. So it's our job to make sure that they are getting the care that they need."

> "We work from a PD [position description] that is as a RN/EEN so technically we can and sometimes are in charge. We just ring an RN if they're not here and we need something."

> "…I work under the directions of a RN. It helps to be a team leader for the PCs, [UHCW] to direct them and make sure that the residents are getting their hydration, nutrition and they're getting all their cares they're needed and that the PCs are following their care plans and the rules and regulations of how many people to use a lifting machine and all the things like that."

> "So I'm on the floor to oversee what's happening and work under the directions of the RN, give out medications, see people when they're sick."

> "Some are good and others I left because I didn't agree with what they did."

> "I look after all the staff and residents within the hostel area. That's my role. I have a passion to be an RN or paramedic but who knows. That may come in time. I do just want to learn more, then I can do more. I love working in aged care."

The concepts of a shared role in care coordination appeared in the anecdotes from the EENs. These anecdotes discussed a shared position description and the need to coordinate care in the hostel or dementia-specific units without the direct supervision from an RN. All interviews conducted shared this concept. A number of new concepts appeared from the EENs, particularly in the *need to provide care*, *the want to learn more*, sometimes *in charge*, and *oversee what's happening*. A further participant shared the notion of *role model* with the desire to be an RN.

The development of the leadership role of the RN started to appear. The leadership role of the RN was outlined by the EENs through the anecdotes provided. These included:

> "…a good team leader that knows the staff, knows her residents, and can send the staff in the proper direction. Whereas a less experienced one doesn't know the staff, doesn't know the residents, so it comes a little bit more than when they rely on us."

> "We step up a little bit and guide them [UHCW] around as to the residents and the staff. So we basically all work as a team for the best of the residents. But obviously the better the team leader at the top, the better it comes down lower as well."

> "…checking and if a problem arises I go and see the resident and see what is happening and then contact the RN if I think further assessments or cares are needed that I can't do or shouldn't do."

> "As much as I know I can do, it is also about scope of practice, some of these are outside my scope of practice."

> "I've basically worked all over the complex under the different RNs that have been here as long as I have. Down in the hostel though it's really changed a

> lot down there, stability is one thing I have to deal with or the lack of stability of the RN down there, yeah."

> "…the RN here has the last say, they make the decisions, because they have to own them. It will be them that gets in trouble if something has not been done right."

Working with the RN was a clear point of discussion that arose from the narratives provided by the EENs. The need for decisions to be made was apparent and the sense of isolation both on the part of the RN and the EEN were observed. The complexities in practice again appeared and further concepts emerged in relation to scope of practice. This scope of practice a concept that the EEN observed in the day to day work conducted in the facilities. This day to day work was inclusive of the EEN coordination role in the hostel and dementia-specific areas of the facility. For the EENs the desire to work independently was apparent however the verbalisation of the need to follow the direction of the RN was spoken. A dichotomy appeared in what was regulated as needing to occur to what in realty was able to occur particularly at times when only one RN was on shift. The physical separation of staff working in different buildings yet reliant on the RN for assistance when a need arose was discussed. The common thread apparent was in the desire to have a level of individual autonomy in the work conducted.

Anecdotes that referred to *the need to contact an RN*, *may involve us*, *in a separate building*, *make a judgement* and *contact by phone* and *scope of practice* were key areas identified by the EENs. The anecdotes shared:

> "Most of them involve us in the decisions that are needed, you know, they might ask our opinion, see what the resident was like when we last saw them or provided cares. But not all the time, some RNs just do their own thing and tell you what needs to happen, I don't think they get it, we are all here together."

> "…the RN is in the nursing home, it's a different building, so if I need her I have to contact her by phone. I usually do this if someone has become unwell, or a family member is not happy."

> "There are a variety of reasons really it just depends. I need to make a judgement or if I think that the problem needs an RN I will call them, if I'm not sure I just give them a ring."

The key concept that arose from the EENs was one of decision maker, supervisor, role model and accountable entity. The anecdotes reflected the need for the RN to provide guidance and support to teams, to have the ability to work with staff, and to provide guidance with care decisions. The narratives also highlighted the concept that the RN was the central point of contact, often separated by space, time constraint and with the need to prioritise and triage the most pressing area of need to attend first.

A new area of discussion arose in the scope and breadth of the role of the EENs. This identified for some settings, a dual position description existing for both EENs and RNs, with a delineation between the two positions provided in the detail. This delineation was in the inability of the EENs to assess or evaluate care. There was a point of discussion from the perspectives of the EENs that saw their role as being capable of decision making yet limited by the regulatory scope of practice. The anecdotes further identified the reliance and dependence on the role of the RN to respond to questions raised by the EENs. Key concepts that arose in this regard related to the RNs ability to navigate both practice challenges and the inclusion of the EENs in the decision making process. One EEN described the role as:

> "Well you really have to want to work in the aged care area, it is not an easy or rewarding role to have. I know that myself. There are many demands on you and lots of residents to look after. In the dementia unit things change all the time. A person's mobility, swallow or personality will change, sometimes regularly. They're not the person that they used to be."

The complexity in care resonated from the anecdotes alongside the need for ongoing care, assessment and implementation of strategies to assist in the quality of care of residents. It was in this complexity that the leadership role of the RN came to the fore. It was the RN who had the expertise, knowledge, scope of practice and accountability to ensure that residents were assessed and care provided was appropriate to the resident's needs.

The characteristic of clinical lead and the dynamics that evolved in the team were shared from the EENs and the RNs working as care coordinators. The EENs role of care coordinator required working with the RN with a shared understanding of the areas of care that each role provided. The EENs outlined:

> "So this RN (RN) I worked with, she was working in aged care because she couldn't get a job anywhere else, well she didn't do much, only what she really had to."

> "I had one situation once before where I was absolutely basically reduced to tears when somebody – an RN – and, needless to say, she's no longer here. The environment – some people abuse that leadership position."

> "…we communicate well, some RNs better than others but the liaison with the RN at the beginning, throughout as needed and at the end of the shift happens. Whenever we need her during the course of the day, we call and she responds."

A broader discussion with the EENs occurred. One participant explained in detail the story of caring for a lady who was unwell. The particular RN informed the lady she would '*fax the Doctor*'. The next day, the doctor still hadn't visited and the lady remained unwell. The RN was contacted again, this time the lady's family were questioning where the doctor was. The RN again replied she would '*fax the Doctor*'. In frustration the EEN sought assistance from the RN engaged in the quality and aged care funding instrument (ACFI) role for assistance. The outcome this time was different,

> "She came and saw the lady who they thought might have a UTI. She didn't fax the doctor again but rang him and he came in to see her at the end of his day."

This was one story that was revealed through the duration of the interviews. Explicitly it defined the basis for a minimum expectation that staff have on the role of the RN in providing mentorship and guidance with clinical decision making. The reasons for the delay were not discussed however the discussion did entail an acknowledgment of the large numbers of residents in the scope of one RNs role to coordinate, review and act on situations that arose outside the everyday 'norm'.

The EENs expressed many anecdotes in relation to their experience of working with the RN. The leadership role and team communication was an area where all EEN participants shared anecdotes. The EENs outlined:

> "…a good team leader makes an awful lot of difference to your day. A good team leader that knows the staff, knows her residents, and can send the staff in the proper direction."

> "…a less experienced one doesn't know the staff, doesn't know the residents, so it comes a little bit more than when they rely on us. We step up a little bit and guide them around as to the residents and the staff. So we basically all work as a team for the best of the residents. But obviously the better the team leader at the top, the better it comes down lower as well."

> "… it works well, when they come around first thing and talk with us, find out what has happened and what is now happening. If we know that they know then I feel supported. No two days are the same but if we start this way, at least we have a base."

> "…to share that information. Then again, I get the same thing. One's not so forthcoming in sharing information. She's dealt with doctors so I won't get that handed over until the following day."

The concepts that appeared from the discussions surrounding communication and leadership identified further the complexities in teams and team dynamics, and the influence of the RN and the EEN roles in care decision making. Concepts also included role modelling, being visible to staff, being approachable, knowledgeable and inclusive in the decision making process.

The EENs spoke highly of the role of the RN and shared their reliance on them. This was a reliance related to trust and the ability of the RN to be there when needed. One EEN participant shared a story of caring for a lady who at 103 years of age, passed away. The EEN shared the experience of caring for her over many years, nearly her entire time working in the organisation, and the heartbreaking day that she passed away. It was at this point that the participant was full of emotion and praised the words, the compassion and the professionalism of the RN who showed the empathy, support and space needed by the EEN during this time of grief. It was her expression of the follow-up with her to ensure her grieving was allowed, appropriate and supported that was most appreciated. It was these kind gestures and level of empathy that added a greater emphasis to the leadership role of the RN in residential aged care.

7.3.1 Concepts arising from the role of the EEN

The scope and practice challenges of the EENs became apparent in hearing the shared experiences of the participants. The stories revealed from the narratives of the EENs were remarkable, and one that shared the want to care, the need to provide, yet the confusion of their role in the reality of the work they engaged in, and the direction they followed. Leadership was seen in the delivery of care and in the coordination of UHCWs in the day to day workload. The leadership seen in the EENs role was not formally recognised nor one that held carriage of accountability to the degree or stature of the RN according to Australian registration standards (AHPRA, 2015; NMBA, 2016a).

Key concepts have been identified from the descriptive nature of reading and re-reading the transcripts shared by the EENs. The concepts that emerged were inclusive of trust, accountability, working together, guiding care decisions,

navigating scope of practice challenges, being a liaison, a mentor and a go to person. Ultimately the EENs saw the leadership role of the RN as the authority to trust, the decision maker, the expert, and the accountable entity. The EENs further saw the idealistic leadership role as one that was inclusive of clinical care staff in the decision making process. The key concepts from the perspectives provided by the EENs included those shown in Figure 2:

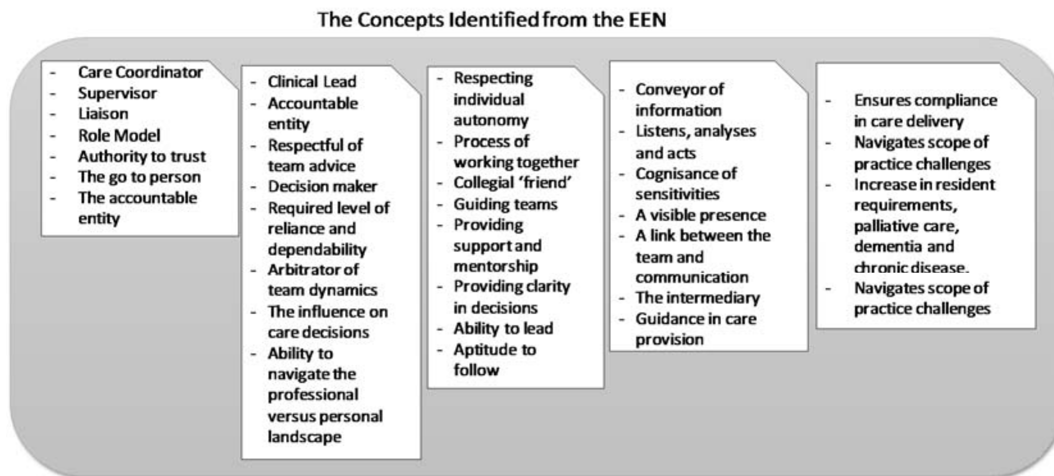


Figure 2. Leadership concepts arising from the EEN

7.4 THE DESCRIPTIVE NARRATIVE OF THE RN

The clinical care staff of the EENs and UHCWs have spoken of the leadership role of the RN in residential aged care. It is a role that has a strong link with the role of supervisor or coordinator, however it is a role that also displayed many qualities in providing direction to the team. For the RN how the role was perceived differed in some areas to that of the UHCWs and the EENs. In other areas a confirmation of already identified concepts occurred. The RNs provided their own descriptions of the leadership role held. These descriptions further add to the overall synopsis of the leadership role held by the RN. Likewise to other participant groups the quotes provided by the RNs have not been attributed to an individual or facility.

The scope outlining areas *of change*, of *a busyness in the day to day routine* and *of communication and rapport* was presented. The anecdotes heard from the RNs further enlightened more detail on the leadership role they held.

The RNs outlined:

> "…the carers are more hands on, so we [RN] rely on them to tell us if a problem happens… they're attending to all the [ADLs], assisting residents with obviously meals, taking them to appointments."

> "…liaising with the doctors, liaising with family members. Then reporting to obviously their clinical nurses and management as well, so that's a different role there for the RNs.

> "….obviously we need to make the decisions because – we're here on our own. So we've one RN here. We've got an EEN as well in the hostel, but the RN, that's me, is making decisions."

> "…there's also answering queries from the staff. If they like to go down and have a look at something that they're [the UHCW is] concerned about, that they find you in their course of hygiene."

Resident relations became a key area of discussion with the RNs. It was in the relationships that the RNs held with staff, management, families, medical and allied health visiting staff and with the residents that was important. The diversity of the conversations and the need to be diplomatic, yet at times firm in the decisions made proved challenging for the RNs. The diplomatic nature of the role discussed:

> "So you've got to be welcome to go down to them because it's important if they ask you to do something – that you do it. If you don't, they won't ask again and things get missed in the future. So you've got to be very approachable that way."

> "…so the day is caught up in resident relations, making sure you've got a rapport with them so that they can feel free to tell you whatever they need or worry about."

The anecdotes shared the link that the RN was the provider of communication of care requirements to the UHCWs and the EENs and the role in sharing aspects of care to the hierarchy of nursing staff and management. This link formed a bespoke connection between clinical care staff, the resident and organisational management. The complexity in the concept required the RN to have the skills and knowledge at the operational level and the knowledge and know how to share the required information with organisational management structures that contend with aged care funding, compliance and regulatory monitoring matters. For one RN an anecdote was shared of her first encounter working in a residential aged care setting:

> "When I came into nursing even – especially in an aged care context, just my age and maturity it was quite overwhelming to step in as a new RN and be told right, here's your team, you're in charge of this nursing home for the shift. I was what? ….19 years old having care workers who were very experienced and EENs who were very experienced and I was supposedly supervising them. Yeah, that was interesting. So I took a break from nursing really. I really wasn't quite mature enough."

The role according to this RN required maturity, linked with the complexity of navigating teams of staff that provided challenges to the leadership role of the RN. The anecdotes are not dissimilar to those expressed by the UHCWs or EENs and identified with the need to mediate staff concerns:

> "…it's about a member of staff, that they might not get on with, to be able to tell you that without worrying about repercussions from that staff member. You can always deal with things like that very diplomatically so it's not coming from one to the other."

> "…keeping the good rapport with the staff, keeping a good rapport with the office and with the resident."

The ability to be cognisant of staff sensitivities was important in the discussions held. The need for the RNs to be respected and trusted was an important aspect in the role. This aspect providing an assurance to the RN that clinical care staff were comfortable in sharing information that impacted both the team and the resident. The need for diplomacy and yet the ability to be the staff advocate was important. These concepts formed key ideals in the leadership role of the RN. It was the RN that further discussed the complexities that arose and the environment that the role was required to coordinate. The RNs outlined:

> "I have a unit to run and then I'm the supervisor for the nursing home and the hostel. That's a total resident number of 137 with multiple pods of staff between them."

> "…you've got to make sure that the cares and the whole duties are done correctly, but not to be overbearing with them, like breathing down their neck and saying, I'll be checking up on you, and things like that, because that destroys any trust that you have with staff. If you start along that road, you never recover because they won't come to you and they won't trust you."

> "So you've got to give them [clinical care staff] a certain amount of leeway to be trustworthy and trust that they're going to do something the correct way, and they do."

For the RN it was the scope of practice that allowed for greater autonomy in practice, for leadership, for care decision making and evaluation. It was these elements that were stifled at times, with the regulation and restriction that occurred in settings outweighing the known capacity or ability of the RNs.

The anecdotes and experiences outlined a supervisory role that engaged all levels of staff working both in the organisation and external to it. What this term *supervisor* meant to the staff and to the resident was again one of reassurance. As one RN participant voiced it was deemed to be *'…. a matter of supervising what's*

happening…' The supervision role provided a presence, a visibility in the facility that, to clinical care staff, provided the opportunity for clarification of questions relating to resident care or staff direction.

The narratives spoke of the behind the scenes moments often negatively driven with complaints management, staff and resident relations or within the domains of regulatory documentation and quality driver compliance management. The RNs described these processes and their ability to navigate their scope of practice and the demand that the compliance and regulation in the residential aged care setting requires. These areas have been described in relation to the care of residents and the support and guidance to staff. These anecdotes include:

> "They [the resident] depend on us to let the doctors know what's going on, so we're the advocate with the GP."

> "…there's also answering queries from the staff."

> "… we do a lot of work behind the scenes that they [other staff] don't see and they're also very helpful with forms and things that we need. But you have to treat them [other staff] with respect….and just the whole day is taken up with controlling the environment, I suppose. …managing the issues…everything that arises in that day."

The focus on the resident was a key concept in the discussions with the RNs on what they determined was important in the leadership role they held. This discussion outlined the need to care, the need to respond, to liaise and to advocate for the resident and, at times for the staff. The anecdotes described:

> "They [the resident] depend on us to let the doctors know what's going on, so we're the advocate with the GP."

> "…they [the resident] view us as almost – what's the word for it – they're relieved to see us [the RN]. If they ask to see a RN, they've got a problem and they want you to handle it. They won't tell the PCs [UHCW] because it's the RN's problem. So they want the boss, as they call us.

The recurring concept of trust appeared from the narratives of the RNs. This trust was a part of the culture and was about the way the RN interacted with staff and, with residents. The anecdotes shared:

> …a big part of that culture is trust and that's for a number of reasons. It's a very complex environment where you're working with people at very different skill levels."

> "So there's a lot of trust you build up as you're working in an organisation like that. Because of the varying levels of skill, you really do need to prove yourself."

The concept of trust was one that was linked with the coordination of care and with the supervision of clinical care staff in the daily operations of caring for residents. The trust extended to one where residents were able to discuss concerns directly with the RN with anecdotes revealing that the resident would often "*…ask to speak with the RN*" or would *"seek clarity or confirmation from the RN"*. Complexity occurred when this trust was seen in the leadership role of the RN in matters of staff or team conflict. At these time the concept and construct of trust was seen in the supervision offered and the problem solving that occurred. This was further explored by an RN participant who articulated what a shift entailed. She explained:

> "… staff should feel free to tell you whatever they need or worry about something. Even if it's about a member of staff, that they might not get on with, to be able to tell you that without worrying about repercussions from that staff member. You can always deal with things like that very diplomatically so it's not coming from one to the other. You can deal with it in a way that there's nobody accusing anybody of doing anything, but bringing

> it to their attention that what they're saying may be taken the wrong way by a resident. Keeping the good rapport with the staff, keeping a good rapport with the office…"

This anecdote extends the concept of supervision to one inclusive of diplomacy and the need to have discretion, yet authority in the management of the work required and the staff relations that existed. The RNs outlined the ability to effectively work with staff as important and this was seen in the relationships they held with staff. Leading from this initial excerpt another RN participant outlined:

> "…if you start along that road, you never recover because they [the UHCWs and the EENs] won't come to you and they won't trust you. So you've got to give them [the UHCWs and the EENs] a certain amount of leeway to be trustworthy and trust that they're going to do something the correct way, and they do. They do – generally do, but if there is a circumstance where something isn't done, to be able to address this fairly."

The dynamics that were required to be balanced in the leadership role of the RN have been discussed from the concept of staff relationships and extend further from the original concept of diplomacy alone. The leadership role of the RN didn't end here but rather was extended further to include the multidisciplinary health care team. This intermediary role of the RNs of liaison, negotiation and discussion with individuals and in groups was essential to care coordination and delivery. The role the RNs discussed was complex and described as:

> "…it is a big role. It can be very tiring because you're with people all the time. The phones ringing, the pharmacists ringing. That's the other thing, have a good rapport with your pharmacist and your GPs [General Practitioner] because if you get their backs up, you don't get – they don't do it deliberately, but of course you keep worrying them over silly things and they're going to say, oh, not [that facility] again, which it can happen [nervously laughs]. So a good rapport with everybody and trying to keep an even ship on an even keel is needed."

This notion of rapport with everyone was a concept of an idealistic nature and an impossible position for the RNs. The desire for an RN to be available and responsive was a complex ask and a difficult action to achieve. The leadership role

of the RN ideally was required to create and maintain positive relations with the management of the organisation and also with peer colleagues. To achieve this communication was seen as the key ingredient. The communications with staff, with residents, with management, with visiting medical and allied health professionals, with families and with external health agencies was complex and continual in each shift for the RN.

Clinical care staff were seen as the eyes and ears within the residential aged care setting that provided the RNs with a sense of security, with a knowing that the environment was safe. It was this expectation and understanding that communication was clear, concise and transparent from the view of a RN:

> "So I come on, I collect the keys from the supervisor and I say, is there any issues? They might quickly say, this has happened. So I'll go to the unit and I'll quickly look at the seven day handover sheet. If there's nothing that needs actioning straightaway, it's like 7:30 on a Saturday morning, I'll start the drug round, and… I'll just go and greet the staff..."

Each example within the narratives demonstrated the effect that power and influence had on either an individual or a group of staff or residents. This power and influence is seen in the communications, the dependability and the reliance on the role of the RN. The art and science of effective communication was clear. Communication was seen as the portal for knowing, for hearing of concerns, and for communicating the required actions or intervention. As one RN outlined:

> "We just know exactly what we're doing, we've got the team working so well. Everyone's got roles in that team and even the carers feel really empowered, so that team is just working well. But then you look at another team that might not be working as well; it might be because you've got a younger RN in there, or I find when the RNs really – we've got some units that they're just so busy. So maybe they don't have as much time to really see what's going on the floor I find, when they've got a really heavy workload. Some of the teams I think the more experienced nurses that we've had here for a while, some of our CNs, they're really good at empowering their teams and empowering the staff. So they don't even need to speak."

This narrative extends the notion of power into different levels of hierarchy within the single role of the RN. It was clear that the understanding of the influence of the leadership role of the RN impacted on the care delivered, the decisions made and the capacity of the team to work well together. The anecdotes discussed the concept of the experience of the RN with the experience determined by the number of years working in the role.

A RN participant explained that the success to leadership was in the trust instilled in staff and reciprocally the trust the RN has in fellow co-workers. More often than not, this trust was expressed through the culture and the team that each individual worked. For one RN she explained:

> "It is a home, it's the residents' home but you really – once you're there for a while it's really like becoming part of a family, especially if you're in a facility for a long time. You have professional relationships obviously with the residents you work with. But they're not cold and clinical and you wouldn't expect it to be like that within a home type environment."

The residential aged care setting has been discussed as a complex environment with known limitations within the fiscal resourcing requirements. *"They* (the resident) "*depend on us to let the doctors know what's going on, so we're the advocate with the GP."* The leadership role of the RN was driven by clinical markers and the need for quality resident care, comfort and reassurance. The complexities outlined provided the RN with a complex domain of providing care and of coordinating care in a team often as the sole RN on shift. The concept of the accountable entity appeared in the narratives of the UHCWs, the EENs and the RNs.

A concept that was discussed related to the remuneration the RN received. This remuneration is known in the industry to be less than RNs in other settings (Segal & Bolton, 2009; Tuckett et al., 2011). The RN viewed the inequity in wages as a key concern in this space and the need for more contemporary education and practice in the profiling of RNs that chose a career pathway in gerontology. This was further supported through the literature where the known wage disparity that exists in the sector in comparison to other employment areas of nursing practice was identified and noted as an obstacle to recruitment and retention in the sector (Segal &

Bolton, 2009; Tuckett et al., 2011). The RNs discussed the current employment situation and remuneration with one participant summarising the concern as a:

> "…sink or swim approach with 'no one to delegate to and no one to bounce clinical care decisions off. As a RN you are the lone decision maker, you do involve the team you have with you however the predominance within this team of UHCWs is proportionally high making clinical informed decisions outside their scope, understanding and capacity."

The anecdote highlighted the accountability and responsibility in the role as the RN was seen as the problem solver, the care coordinator and of the resident advocate and liaison. The clinical care staff expressed concepts relating to change in the residential aged care setting. For some this related to the changes in practice, for others a more global perspective was shared. This global context related to the changes in the aged care industry and the resulting impact on the clinical care staff and in particular the leadership role of the RN.

7.4.1 Concepts emerging from the RNs

Concepts arising from the anecdotes were extensive however key themes started to emerge. The concepts surrounding the requirement of the leadership role of the RN to display confidence, have the ability to work with people, mediate disputes, listen, hear and absorb information, and be a decision maker were prominent across the UHCWs, the EENs and the RNs. The need for the RN to have experience and understanding, and have the knowledge to address issues as they arose was important. Coinciding with this was the ability to speak out when care and care decisions were not ideal. This highlights the fundamental premise of the importance of communication and advocacy to both problem solve and to foster staff autonomy. These concepts were believed to be ideal and based on the integrity and reliance of the RNs with the knowledge, the 'know how', the ability to coordinate, and to empathise in assisting the team in care provision and the coordination of each shift.

The RN leadership role in the residential aged care setting is a core position. The collective joining, linking and associations between the concepts discussed through the descriptive narratives of the clinical care staff and the RN have outlined

the complexities in the role and provided the baseline of the key areas that have emerged. Figure 3 outlines the key leadership concepts that emerged from the research relating to the leadership role of the RN. These concepts arose in the ability of the RN to apply these concepts in practice. This application more of the 'doing' and practicality of the concepts found in the day to day leadership provided.

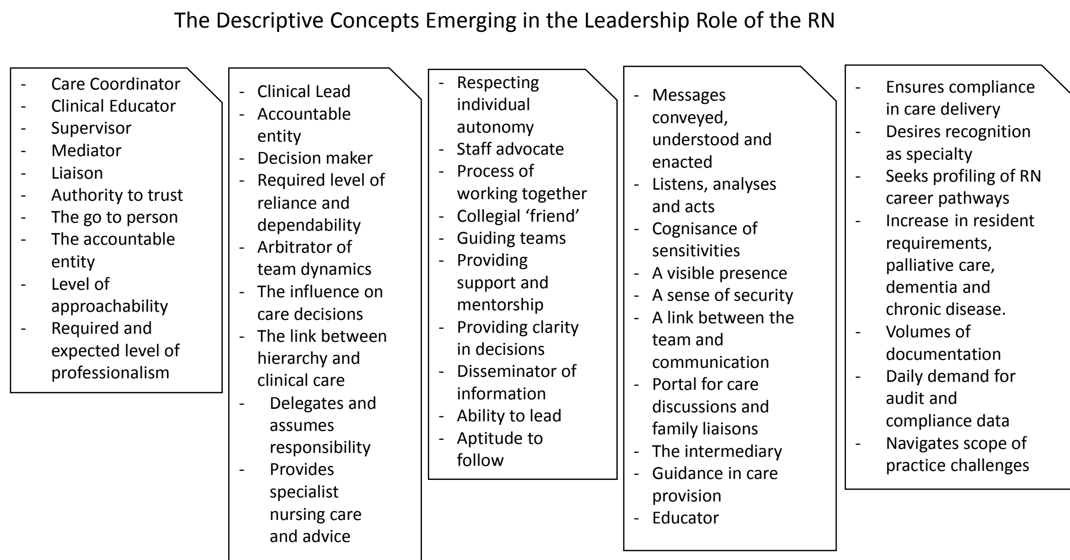


Figure 3. Leadership concepts arising from the RN.

The leadership role of the RN has been captured through the descriptive anecdotes that have outlined the need for communication, for coordination, and with the RN as the accountable entity.

7.5 THE CHANGING FACE OF AGED CARE

The changing face of the aged care setting was discussed by all participants interviewed. The descriptive analysis outlined similar emerging concepts that were described as having impact on the leadership role of the RN. Discussions surrounding the changes seen in aged care settings by the clinical care staff require further exploration. It is these discussions that add a further depth to understanding the leadership role seen, heard and enacted by the RN in residential aged care. It is these discussions that add to the context of working in the residential aged care setting, the organisational nuances, the staffing complexity and the care requirements of the residents.

Staff identified a change in the type of residents being cared for, and further discussions were strong surrounding the context relating to legislation, work practice and consumer demand in the workplace. The changes that presented were not only in the individual settings but more broadly linked with the Australian health and aged care system. These were changes that as employees in the sector staff have seen, have lived, and have complied with or tried to understand. Collectively, the anecdotes provided by the clinical care staff shared aspects relating to the resident staff now cared for.

As outlined by one UHCW participant:

> "…a lot of them are – a much higher percentage of them are now a full lift enhancer or at least a two person assist enhancer. A lot more of them are requiring supervision or assistance with their meals, can't do as much for themselves necessarily. … I believe a lot of that is actually the paperwork required to document all of that. Some of those things were probably there but now we have to document everything, the behaviours and assistance with meals, supervision with meals, is something we didn't do so much of when I first started."

The perspective from an EEN expressed:

> "…however we don't usually have RNs in charge of the hostel, this is usually an EN. I suppose it does raise questions on the scope of practice of the EN in this setting but I know our facility works the same as many others in the aged care sector. We just don't have the luxury to afford RNs in all the areas, however with the changing complexity of our residents in Australia this would be the ideal way to go."

This shift in the type of resident requiring care in the current climate highlighted a more complex resident with multiple health concerns, conditions of chronicity and long term management, an increasing number of residents with dementia and the need to utilise skill and expertise in palliative care requirements. Education was discussed as an integral concept that emerged in the role of the RN with in-house education provided to EENs and UHCWs on key issues or resident need areas. One particular anecdote discussed the education provided to UHCWs at a time when palliative care needs were evident in the facility.

The anecdote outlined the need for the education, the support and the level of experience to be able to care for residents at a time when palliative care was initiated in the residential aged care setting. For one RN participant her story was clear about the fear and trepidation experienced by two UHCWs in providing care to a lady in the end stage palliation cycle. The story begins at an education session where the RN is providing education to the UHCWs on practical skills for completing hygiene cares for a resident who is bed bound. The situation outlined one area, the space of caring for palliative residents, specifically encompassing hygiene needs in the late stages of palliative care where comfort management was key. The UHCWs contacted the RN on numerous occasions in the shift as they felt uncomfortable in providing the required cares to this resident. The UHCWs worried the family would ask questions, worried they would further exacerbate the resident's condition and worried that she may pass away during the course of attending her. They required guidance and support on how to proceed, and the empathy and understanding from the RN was an important feature, however one where the RN had conflicting priorities arising in the shift. The RN reinforced the education provided and supported the staff throughout the course of the shift as best she could.

> "…This lady had been with us for probably five to six years…. The staff knew her really well and were very emotionally invested in her, and she was dying. They accepted that, but they really wanted to do the best for her."

Staff had recently attended education that entailed:

> "…we went through the hot towel sponges, all the aromatherapy things, all the oral care, just the very practical stuff that the staff need. We actually practiced this shower cap scenario in the session."

The situation hit a climax where both staff and the family were becoming stressed in what to do next, so *"I focused them back on the training we had just completed"*. The unfortunate reality was as an RN "*I needed to be in many other places as well."*

> "…staff said why don't we wash her hair? Because she hasn't had her hair washed for a couple of days. So they got the shower cap. So they were talking to the daughter and it was like they were in this hairdressing salon. Her daughter just said it was great – and literally 45 minutes later she died. That

> actually made me feel so proud that they actually translated into practice what they had been taught. It's self-satisfaction in the job they're doing…."

It was the RN with the knowledge, the know-how and the understanding of the medical related concerns that arose. Key to this was the education provided by the RN to the UHCWs and the EENs in the residential aged care setting. This was a continuation of the complexity and diversity in the role and one where dependency, knowledge, skill, diplomacy, trust and the ability to educate along the way all intermingled as a fine balancing act. This education aimed at providing the RN with a level of confidence in the clinical care provided and within the decisions made independently by the clinical care staff.

As one RN outlined:

> "…if I think back to when I first started in aged care, so about 15 years ago and being a CN probably about 13 years ago; I just think the complexities of like the residents coming in to aged care now. It's much more demanding – I don't know if it's because of the funding instrument that's changed, or just a lot more documentation as well. It's just I've found that when I first started compared to probably three years ago when I was in hostel here, it just has gotten much, much busier."

As one UHCW shared in relation to aged care standards and RN led leadership:

> "…they are really important, the residents we care for but the standards make sure we do all the right things. I see the RN has to talk with us all to know what to put in the paperwork to meet the standards."

This shift in resident type was not the only factor that staff identified as an area of change. Government policy and funding models identified the need for strict compliance with documentation standards applicable to all aspects of care and behavioural monitoring. The clinical care staff spoke in detail of the changes within this area of practice, an area that removed the RN from the hands on doing with residents and place them in a myriad of documentation requirements.

In relation to the role of the RN:

> "...the RN has got horrendous amounts more paperwork because she's in control of documenting all of this. You know, she's the one who decides that all that paperwork has to go out and then she has to correlate it and work out a care plan. So, yes, her role or she's got to assimilate a whole lot more information on paper to then put together a care plan."

An UHCW spoke in detail about the quality of care and the changes within the setting:

> "I think, once again because we're more aware because we're doing all these charts, behaviour charts, input, output, all that kind of thing which I can't remember but I don't think they did any of those when I first started. We might have done the very basic stuff but by doing the charts, although it takes us a huge amount more time, it also makes us more aware and gives us a better picture of exactly what's required even though some of it seems a little bit mundane and unnecessary."

This was further defined through a UHCW:

> "I think in general the staff-resident ratio is probably about the same because the residents are – their needs are greater, they're taking us longer."

With over fifty years of cumulative experience the EEN participants outlined many and varied changes broadly in the aged care sector as a whole and more succinctly in their role. An EEN spoke of the change in a typical resident in the current climate:

> "…. usually they are old, I mean in the 90s or older, many don't even come to us now until their mid to late 90s. As I said they need help with everything or at least most things and a lot of watching. Falls are a big problem, so too are skin tears, but what do you do…we can't be everywhere at all times."

This summary was in stark contrast to the earlier years that an EEN participant remembered working in the setting when she first commenced as the EEN in a hostel environment.

This EEN participant identified:

> “When I first started here, it was a low care facility and we didn’t have anybody that needed more than walking to the dining rooms for meals. That was all that we had.”

The current climate in residential aged care allows a resident to remain in one area, for example the hostel environment may now be the home of a resident for the duration of their stay. This adds an additional complexity in the delivery of care to residents. Further complexity was added to the leadership role of the RN as care and care decision making was required and needed from a different area of the facility to where the RN was located.

As the clinical care staff outlined:

> “Aging in place as I said is about people staying where they are. We used to have people in the hostel that were able to do a lot for themselves but might have just needed someone with them for their safety or for showering or to assist with their mobility…but now… we have residents that are with us when they are palliative.”

> “We don’t move them anymore, or rarely do we move them. It’s only if the family or we see a really big issue with them staying here. …It means we are doing more and more for them....it’s nice but really hard as our staffing doesn’t always reflect what we need.”

> “In a nutshell we used to have residents classified as low care but now this is not the case. To get a room you really need to be high care, the demand is so great. Not sure the resourcing has increased with it, but you do what you can.”

This experience outlined the shift in care provided, particularly from the perspective of clinical care staff working in the hostel environment. It was this change that signified the rationale for the need to work in closer alignment with the RN. It was in this current environment that the leadership of the RN was most important. Where once care provision was less directed, less complex and more

about the engagement with the resident in the planning and provision of some cares and more social driven experiences the current climate was described quite differently.

Overall, the conversations outlined an inherent desire to care, to work in the aged care system and to provide to those as they aged, as they required palliative care plans or as their social and health needs altered. It was through the expression of the RNs that the notion of peace maker and problem solver arose in the leadership role outlined. The stance of peacemaker and of problem solver an area of discussion greater than just the scope of clinical decision making. It was this area where anecdotes articulated the concept of team and team dynamics and the understanding of the leadership role of the RN in the management and discussions with staff occurred.

The leadership role of the RN was seen as a role that established the players and set the tempo between the clinical and administrative demand that presented. As one RN described:

> "I've worked in the funding team and I'd never want to do it again. But we need it; we need the funding to provide the services and to have the staff. But we really have to jump through hoops. …at the bedside in terms of complications, in terms of what you document and how you document something. How you document a variance as to where that funding will hit… Whereas in the aged care sector if you improve somebody's condition you're likely to lose some of that funding."

The RN was seen to manage resident and staff relations and yet was employed to coordinate care for residents from the planning of care through to the evaluation, and the derived outcomes of that care. This was a role that, although led and driven from within the leadership role of the RN, was one that also encapsulated a wider team of individuals external to the organisation and yet, intricately engaged in the social and medical care needs of the residents in the settings.

7.6 CONCEPTS IDENTIFIED IN THE LEADERSHIP ROLE OF THE RN

The summation and grouping of the key concepts that have arisen from the transcripts of the UHCW, the EEN and the RN is shown in Figure 4. The initial review of the transcripts has provided a comprehensive beginning to understanding the complexity in learning more about the leadership role of the RN. Collectively the grouped concepts provide a summation of the leadership role.

These concepts are identified in Figure 4 and include:

Figure 4. Key concepts of the leadership role of the RN

The clinical care staff has spoken of the changes in the aged care setting in Australia. This broader discussion of the changing face of the aged care setting has been perceived by the clinical care staff as an important area in the way the leadership role of the RN is conducted. For this reason a collective snapshot of the anecdotes from the clinical care staff share this concept. These concepts identified the complexity surrounding the leadership role of the RN with multiple aspects relevant to the role held and enacted in providing the leadership to staff. The concepts were seen as the ability of the RN to:

- Have a sense of being that is able to provide decisions
- Include staff and influence best practice care
- Respect an individual's autonomy

- Provide a sense of knowing that the RN will be there
- Provide guidance and shared learning in the practice of caring for residents
- Enable staff to act according to a residents needs

The concepts also outlined the ability of the RN to know and understand many of the aspects and responsibilities of leading teams with reference to knowing and understanding:

- Team dynamics and the diplomacy to manage relevant situations
- The legislative requirements in practice
- The health care needs, care planning requirements and the implementation of these in practice
- The scope of practice challenges
- The changing face of aged care.

7.7 CHAPTER SUMMARY

The leadership role of the RN has been identified and described through the narratives provided by the clinical care staff. This leadership role has been recognised as a complex role with multiple dimensions and sections. Chapter 7 has provided the descriptive analysis of the narratives obtained. This beginning has identified concepts relevant in the definition of the leadership role of the RN. The concepts that have emerged are further explored through a more thorough interpretative phase of data analysis in Chapter 8.

Chapter 8: Understanding the RN Leadership Position

8.1 INTRODUCTION

Chapter 8 explores the interpretations gained from the descriptive analysis presented in Chapter 7. This chapters extends the descriptive analysis through an interpretative lens, to add greater depth and substance to the 'what is' of the leadership role of the RN in residential aged care. The interpretative analysis in section 8.2 highlights the concepts and shares the condensed meanings that emerged. The first area in the interpretative analysis is shared in section 8.3 with each of the sub categories of the understanding of the leadership position discussed. A chapter summary is provided in section 8.4. Chapter 9 continues the discussion with greater depth discussed through the application of leadership in practice and the resultant meanings that emerged from the research.

The words of Lenny Bernstein as cited in Cott (2013, pp. 18 - 19) outlined 'the conductor must not only make his orchestra play; he must make them want to play…' This quote is a succinct synopsis of the complex web of interconnectedness of the role of the RN in the leadership seen, heard and articulated by the clinical care staff in the residential aged care team. This definition identifies with the conductor and the ability of the RN to work both individually and in a team. This approach to the leadership role was seen in the ability of the RN to orchestrate the leadership required by the team, the instruments, in caring for the residents in the aged care setting. The identification of two categories important in the leadership role of the RN emerged from this analysis. These categories related specifically to the two areas of the leadership role of the RN that the clinical care staff of the UHCW, EEN and the RNs themselves outlined. The two areas of practice were the ability of the RN to have:

1. an understanding of the leadership position held,
2. the ability to apply this leadership role in practice.

8.2 THE EMERGENCE OF THE MEANING OF LEADERSHIP

The first category that emerged was referred to as the understanding of the leadership position. Within this context the UHCWs, EENs and RNs articulated many descriptive anecdotes that defined this category. The development of the aged care context appeared as the understanding of the leadership position emerged in relation to the RN and their capacity in their position, their delegation and their authority. The descriptive phase of analysis formed five sub categories of ‘understanding’. Each of these sub categories was distinct yet collectively linked and allowed for the interpretation of the essence of the leadership role of the RN to emerge. Figure 5 shares the category, sub categories and collective concepts identified by the UHCW, EEN and RN. This summation highlights the amalgamation of the descriptive findings the participants shared into a more structured analysis resulting in five sub categories in the category of understanding the leadership role of the RN.

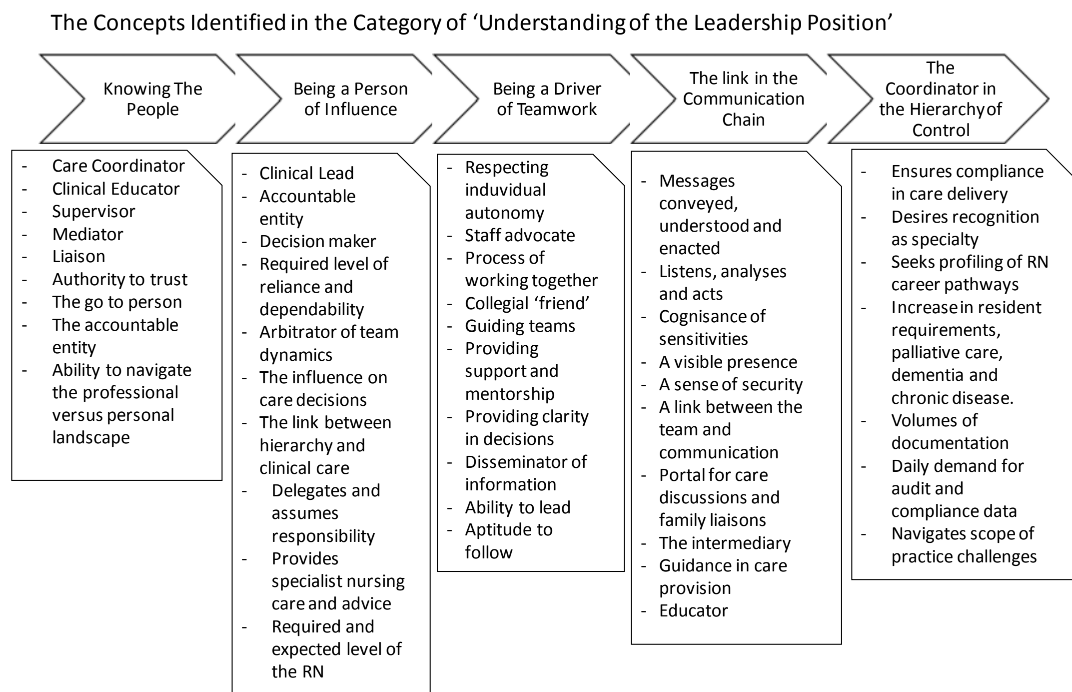


Figure 5. The category of ‘understanding’ of the leadership role of the RN

The five sub categories of understanding of the leadership position are:

- knowing the people,
- being a person of influence,
- the driver of teamwork,
- the link in the communication chain, and;
- the coordinator in the hierarchy of control.

The identification of the second category in the leadership role of the RN was identified as the ‘application of leadership in practice’. This category of application required consideration of the extraneous entities that formed the relationships, the culture, and the ability of a team to put what was asked into action. This application of leadership in practice referred to the ability to provide the guidance, the shared learning and the perception to see and allow staff to act in the day to day operations of care delivery. This leadership further demonstrated the ability of the RN to know and understand the dynamics, the legislative requirements and the nuances to provide the practical application required. This was particularly important from within the leadership context of the subtleties that arose in the practice domain of working in a residential aged care setting.

The category of the application of leadership in practice evolved with the grouping of the descriptive phase of analysis into five sub categories of application. Each of these sub categories was distinct yet collectively linked and allowed for the interpretation of the essence of the leadership role to emerge. Figure 6 identifies the categories relating specifically to the ‘doing in practice’ that emerged from the concepts in the collective descriptive analysis phase. These concepts in the application of leadership have been collated and presented collectively as a statement emerging specifically from the sub categories relating to application.

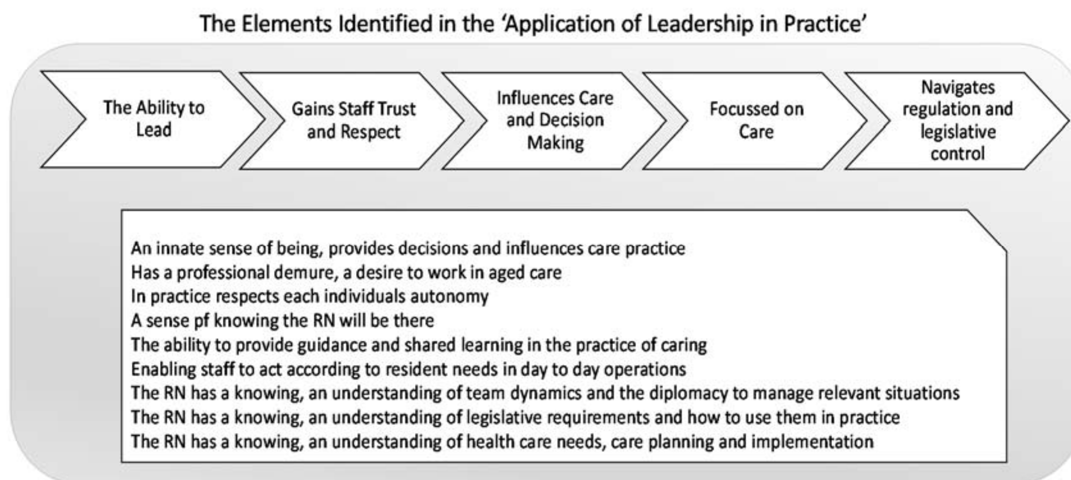


Figure 6. The category of 'application' of the leadership role of the RN.

The five sub categories of the application of leadership in practice are:

- the ability to lead,
- gaining staff trust and respect,
- influencing care and decision making,
- focussed on care, and;
- navigates regulation and legislative control.

8.3 THE 'UNDERSTANDING THE RN LEADERSHIP POSITION'

The first category identified in the analysis was that of understanding the leadership position. This understanding was defined in relation to the RN having an inherent comprehension of their position with particular reference to having good judgement, aligned with insight and the ability to realise and grasp the human, physical, fiscal and psychological demand of the residential aged care setting. This definition illustrates that an RN must enact their understanding of the leadership position to effectively lead a team of staff within residential aged care settings. The identification of five sub categories in this understanding of the leadership position occurred. These five subcategories were identified and defined as:

1. **Knowing the people** – establishing links, respect and trust with the staff, the culture, the communication and the systems in which the RN works, makes decisions, is trusted and respected, and provides education.

2. **Being a person of influence** –being knowledgeable in the decision making processes of the RN: the discussions, the organisational policy and operational influences on care decisions and the capability of the RN to navigate these to an agreed outcome.

3. **The driver of teamwork** – involves the delegation, the leading, the following, the respect and the trust of the RN from within the team and the understanding of how this all operates to benefit the residents, and the recipients of the care.

4. **The link in the communication chain**– entails the awareness of the RNs of written instructions, comprehension of verbal handovers and medical orders, the organisation of social outings and staff delegations, and the management of conflicts and questions from staff, residents and families.

5. **The coordinator in the hierarchy of control** –the management from within the role of the RN of the influence of the Aged Care standards, the funding models, the legislative requirements and their effect on the team, the residents, and their families. The terminology of management is defined as the decision making, the physical supervision of care and the political landscape of residential care provision within acceptable practice parameters.

The definition of leadership heard from the voices of the clinical care staff identified a complex sounding, yet somewhat simplistic notion of leadership. The five subcategories of understanding of the leadership position collectively identified that the notion was about the rhythm, the pace and the beat of the leadership. This rhythm was described as the timing of the events on a human scale. It was determined that what was heard was recognisable and transferable through understanding of the leadership position to the people on the frontline of clinical care, their needs, their securities and their work plans. The overarching theme in the interviews was about the resident, what they needed, understanding what their story was, and how that affected their care and what level of intervention was required. The sub categories of understanding of the leadership position provided key information that the RN required in undertaking the leadership role.

8.3.1 Knowing the people

Knowing the people became a great asset for the RN in the team. It was the RN who facilitated the working with and in the team. It was about knowing the people who communicated with and through each other in the setting to achieve quality resident outcomes and staff satisfaction that was important. The interviews highlighted the leadership role of the RN as one of being concerned with people. The people were described as the staff and the residents, the families, the multi-disciplinary team and the broader health community. The literature asserts that the staffing teams in residential aged care settings are complex with UHCWs, EENs and limited RNs to complete the care to vast numbers of residents (Anderson & Reuben, 1998; De Bellis et al., 2013; Jeon, Merlyn, et al., 2010). This research concurred with the literature and the Productivity Report in Australia (2011) that quantitatively identified that there is an increasing trend in the residential aged care setting to employ less skilled staff.

The staffing and skill mix in the residential aged care setting is complex with high numbers of UHCWs. Knowing the people was a key trait in the leadership role of the RN as it is in this knowing that the relationships and support mechanisms developed. Traditionally the aged care sector has been faced with challenges associated with the conduct of staff roles which in turn have affected the RN's ability to lead a team, maintain job satisfaction, retention and motivation in the work setting (Bamford et al., 2013; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006). The RN holds an important leadership role in communicating, guiding and supporting teams that provide the care to residents each day. Through interactions with people the RNs gather the required information to make appropriate decisions surrounding care provision.

Key to the guiding and supportive role of the RNs was in the relationships held with staff. These relationships were key to the development of clinical care plans and engagement of clinical care teams in the completion of work requirements. The communication in the team and with the RNs and the comfortability of being engaged in a positive workplace culture prevailed from this concept. This research identified the complex web of interactions with the RNs. These complexities were seen in the relationships with staff and with the many roles that the RNs engaged in.

Cummings et al. (2010) identified in the literature that work conditions, staff behaviours and relationships between staff were areas of challenge in retaining RNs in the residential aged care setting. RN recruitment and retention in the residential aged care setting was seen in the literature and confirmed in this research as a key element in the success of the leadership role however an area that the RNs often found challenging and difficult to navigate (Duffield et al., 2011; Hayes et al., 2012; Kleinman, 2004; Venturato et al., 2007). The RNs expressed the feelings of isolation in practice, and a complexity in the role that often placed the RN as the sole decision maker on shift. The RNs expressed the want to care and a willingness and motivation to work in the aged care setting. This was further reinforced in the literature and in the research undertaken (Anonson et al., 2014; Chenoweth et al., 2010; Pearson et al., 2007; Yun-Hee et al., 2013).

In knowing the people a number of roles emerged that were characteristic in the leadership role of the RNs described by participants. The many faces of the RN were as the supervisor, the intermediary or mediator, the educator and the authority to trust. The research and the literature supports that supervision was seen from the theoretical sense of the provision of guidance or oversight of delegated nursing tasks (Martin & Waring, 2013; Wilson et al., 2013). It was in this definition that the key to understanding the leadership role of the RNs became more explicit. It was in the understanding of the people; the people that the RNs worked with, and importantly, the people that the RNs fundamentally engaged with and supervised in all aspects of the work required. Moreover this supervision was dominated with work teams that consisted of high proportions of UHCW or staff working in isolation in pods or units disassociated from the central residential area in the complex.

The puzzle of the 'what is' of the leadership role of the RN expanded to have the inclusion of the people, their individuality, the team coherence and dynamic, and the need from the RN to supervise, to delegate and to be diplomatic. The literature asserts delegation is a key responsibility of the RN, particularly with the large numbers of UHCWs in the setting that seek the direction and delegation in completing aspects of residents' care (Asencio et al., 2012; Bergman et al., 2012; Klein et al., 2006; Wang et al., 2014). The research identified that the art of delegation was not a skill set that was inherent within the RN but one that required diligence, and an understanding of self and a greater understanding of others to

enable the skills and confidence to delegate to others and to perform the leadership required across the team. These areas of consideration placed the RN at the fore in mediation and negotiation. This mediation and negotiation role was supported in the literature as a central concept in the leadership role of the RN (Asencio et al., 2012; Bergman et al., 2012; Klein et al., 2006; Wang et al., 2014).

It was the understanding of the people and of the requirements needed that provided the RN with the essential strategy to undertake care, or in the delegation of care to others in the team. It was also this understanding of the leadership role that further enhanced or restricted the delicate balance of staff relations in the team. It was the interactions with the RNs that provided the bespoke connection between the people and the influence on care and care decisions and in the communication across and in teams identified in this research. Anderson et al. (2003) and Garber et al. (2009) support these concepts recognising that an interdisciplinary approach to care delivery is important. This interdisciplinary approach further supported through the recognition that residents are unique, autonomous individuals.

The Australian Government also support the concept of individualism with approaches focused in residential aged care settings on the people, lifestyles and health care choices (DoHA, 2012; Ibrahim et al., 2014; Kadu & Stolee, 2015). It was these approaches that added to the complexity of care arrangements and to the need in the leadership role of the RNs as one of care giver, leader, educator and liaison. A role that importantly required the RNs to know the people in the setting: the staff, the residents and the medical and allied health staff that frequented the facility. The literature supports these roles and specifically outlines the role of educator as one inherent with the National Registration standards (NMBA, 2016a; NMBA, 2016b).

The research identified that working with people in care teams and individually with families and visiting health professionals was complex, was multidimensional, and was dependent on the individual communication style of the RN. The leadership revealed the qualities of responsibility and accountability in care and care decisions and yet a dependence and reliability in the education, daily operations of the setting and the complex web of planning, implementing and evaluating care. Dissonance appeared in the complex realm of residential aged care nursing through a web of roles, regulations and care all led and reliant on the

leadership role of the RNs at the coalface. It is well established that there are disparagingly low numbers of RNs employed in the residential aged care sector, further implicating the dependence and reliability that is required of the role (Anderson & Reuben, 1998; De Bellis et al., 2013; Jeon, Merlyn, et al., 2010).

The education of staff was an area in the accountability trail of the RNs. For the RNs there was an inherent need to know that staff completed the required cares in a timely and efficient manner and also in a way that provided the residents with the best care options available. A paradigm evolved from the interviews with all levels of staff surrounding the need for education. The desire to learn was strongly voiced, yet the translation of this learning was often missing in its practical application. The need to provide ongoing educational needs particularly in relation to the fundamental components of care, the reasons for the care, and the changes that could be observed in a resident, was strong. The literature supports the role of the RN as the initiator of in-house education in the residential aged care setting (Bajnok et al., 2012; Cooke et al., 2014; De Bellis et al., 2013; Dignam et al., 2012; Hallinger, 2003). This research saw the RN knowing the people and working with staff in the provision of in-house education requirements relevant to the care required of residents in the setting.

For the RNs education provided to staff in-house was an integral component of the role. The staff expressed anecdotes of learning from the RNs, of asking questions relating to care, to communications and resident conditions. Anecdotes described education sessions of providing hygiene needs to those as end of life neared. The education was both a physical component of how to provide specific care and of an emotional support and guidance with what and how to have difficult conversations at this time in a resident's journey. These concepts are further supported in the literature with research conducted by Marcella and Kelley (2015) focussing on quality of life for people dying in residential aged care settings. Marcella and Kelley (2015) identified that palliative care is a specialised area of care, with UHCWs and nursing staff all requiring training and education for the delivery of such care. Important in this education is the ability of the RNs to provide support for grief, loss and bereavement from a staff member's perspective as it is well established that residents are known and familiar to staff (Abbey et al., 2006; Agar et al., 2012; Marcella & Kelley 2015). These areas have been discussed by participants

however the support and guidance apparent is dependent on the RN on duty, the time available and the knowledge and comfortability of the RN.

The UHCWs sought education and ongoing training surrounding medication administration. This new concept in the skills completed during a shift was daunting for some and came with relevant safety parameters that needed to be complied with. Education was discussed in the literature in relation to the in-house model staff outlined, and also in the capacity of the RNs to gain and seek out education opportunities to provide in the setting (Williamson, 2005; Yun-Hee, 2014). Education was also discussed in the literature as a means of knowing and of understanding the legislative and compliance standards required and mandated in the setting (Angus & Nay, 2003; DoHA, 2006; Hugo et al., 2009). Each of these concepts added greater accountability and pressure on the leadership role of the RNs. The increasing demand and the need to educate and allow staff the autonomy to practice the skills gained was derived through a level of trust and of knowing the people with whom the RN worked. The research discussed this trust and the individualised manner in how some RNs allowed for greater flexibility or team trust than others.

The resulting actions and communication pathways from education to practice was believed to be of benefit to the RNs who saw the UHCWs and EENs as their '*eyes and ears on the ground'*. This team perspective was further reiterated through the RN who viewed an aspect of their role to be the follow-up care or the implementation of a broader range of health care initiatives for residents. To achieve this best care approach the need to educate UHCWs in the setting was important. To know as a RN was to understand, to understand provided the ability to better provide the guidance, knowledge and support needed.

The complex domain of working both in teams and with individuals in a complex landscape was apparent and one often open to subjective judgement and criticism. The research identified a dissonance through the range of complexities and the staffing models that focussed on resident care through the supervision and support provided by the RN. This parameter of leading care and care related decisions to those as they aged was a responsible and specialised area of care. This was further supported in the literature where Martin and Waring (2013) and Wilson

et al. (2013), see the RN as a scarce resource responsible and accountable for not only the planning and supervision of care but importantly as a clinical leader. The clinical care staff expressed the dissonance of needing RNs in the setting that were dedicated and committed to the specialist RN role of leading care to those as they aged. The RNs outlined the complexity in the role in meeting staff, resident and organisational expectations. Knowing both the people in the role and the capacity of the RN was key in providing what clinical care staff perceived as a safe and transparent clinical environment. To achieve this concept the authority and trust in the RN on shift was important.

It was the RN that held carriage of the authority as several participants outlined *'they are in charge'*. The sub categories arising in the research shed light on the often diplomatic communications and interactions with the people that was required to ensure the balance of authority and secondly of degree of reliance in the power relations that existed. Kanter (1994) described both the formal power structures that exist held through positions of authority and secondly those power structures that present through the informal power alliances that form in work teams. de Waal and Sivro (2012) discussed the concept of leadership as one who uses power and influence as motivators to follower colleagues in achieving organisational goals. This approach according to de Waal and Sivro (2012) outlined the results of a quantitative study that identified an inconsistent relationship between servant leadership and organisational performance. Similarly to de Waal and Sivro (2012), this research further concluded that there is a delicate balance between staff and the informal power bases often found within the role of the UHCWs. Findings in this research outlined the development of alliances and noted that informal power structures were exerted from the role of the EEN position when seen as the care coordinator in the hostel environment. This added a compounding effect to the leadership role of the RN and one where responsibility and accountability were entwined in the success of the delicate balance of decision making, reliance, dependence and influence enacted in the leadership role of the RN.

Contrary to this explicit need to be able to work with the people, there was also a need to be able to balance and manage the leadership of the setting. In the capacity of the RNs, the essential components included the coordination of care in the day-to-day operations of the residential aged care facility. The role of the RNs

was one of a leader, to guide care decisions, to provide residents with appropriate clinical assessments and care evaluations and to be the responsible and accountable entity for the 'whole' of care each shift. This research highlighted the concept of the need for caring and dependable staff to achieve best care practices for residents. RNs spoke of a commitment, a desire to lead and a desire to be recognised in the specialty area of aged care nursing. Tuckett, Hughes, et al. (2009); and Tuckett, Parker, et al. (2009) further support these findings with research that focused on the desire to care and the strategies to recruit and understand the negative drivers that are present that affect the work morale of the RN.

Trust as it was expressed, was the one sub category the RNs were required to understand and to have, to successfully guide the clinical care staff each day. However, it was often seen in the expression of the understanding of trust viewed in a subtler and hidden context. The leadership role was about the trust in teams, the trust in individuals and the trust that was felt in the delivery of care and in the communication in, and within the team. This trust, a fine balance between allowing cares to be provided from individuals as deemed appropriate, yet trust that each individual shared and communicated concerns and situations as they arose. The development of a sense of collegiality arose. This concept was identified in the research and supported in the literature where affirmation was gained that supports the leadership role of the RN and their ability to foster an employee's sense of respect and trust in a team (Bishop, 2013; Egan et al., 2004; Faulkner, 2008; Tuckett, Hughes, et al., 2009).

The participants shared anecdotes of a positive nature of how this trust was instilled. Participants also highlighted some of the challenges when working in teams where the need for trust was apparent however time to 'earn' this trust was still required. The notion of 'earning' one's trust was further encapsulated in the leadership concepts attained by the RNs. The literature supports that the RNs in residential aged care settings are able to demonstrate positive behaviours that are known to influence the decisions of colleagues in practice (Bishop, 2013; Egan et al., 2004; Faulkner, 2008; Swearingen, 2004). This influence of the RNs in the team, their communication with the people at the workplace and in the leadership role more globally was identified through the influence the RNs created in a situation or in the coordination and leadership they portrayed. To know the people in the team

provided a transparent means to develop trust, build relationships and foster a positive clinical leadership approach to care coordination and provision in the residential aged care setting. The role of the RN was key in the consonance or the dissonance of this transparency in the settings.

8.3.2 Being a Person of Influence

The notion of influence appeared from the sub categories arising in the research and flow from the transparency in knowing the people in the team. The notion of influence was derived from the decision making processes, the building of trust, the discussions surrounding organisational policy and the operational influences on practice in the setting. The notion of being a person of influence was important from the role perspective of the RNs. It offered assurance and provided the guidance and sometimes the authority in decision making. The influence surrounding the decisions made, the processes followed and the navigation of these systems joined collectively to end with an outcome for a resident or for a staff member. The term influence was defined as the effect one person or an intervention has on another, or alternatively, the influence was seen as the power a person exerted on others (Kanter, 1977, 1981). The definition discussed two concepts, the first being the effect an individual has and, secondly the power that is exerted.

The concept of empowerment was articulated in the discussions surrounding influence and power. The collective influence and power exerted by various levels of the clinical care staff in the team, and the hierarchy of control that was present at each of the research sites, was apparent. It was from this presence that both the power and influence and the reform and restriction that surrounded staff was visualised. Kanter (1977), and Martin and Waring (2013) outlined that power and influence are not strange to workplaces and are a common thread in setting the climate, and establishing interpersonal and team alliances that can promote and enhance both positive and negative influences.

Experience was also seen as the level of understanding that the RN had in the residential aged care setting, the priorities, the team dynamics and the influence that this expounded to others. Compounding this concept further was the notion that the RNs were not the clinical lead in the decision making process in all areas in the

residential aged care setting. In many instances the EENs assumed the role of care coordinator in the hostel or dementia units. These environments were usually segregated from the main residential setting sometimes in separate buildings, sometimes behind a closed door or a distinct area of the overall setting. The decisions made often encompassed the role of the EEN with a further increased decision making capacity requested as required, from the role of the RN. The literature identified with the utilisation of EENs as part of the cost saving mechanisms of facilities (Milson-Hawke & Higgins, 2003).

The RNs were seen in all interviews as the accountable entity. The role was seen and expected to provide the leadership for staff through the physical, the psychological and the caring aspects of working for residents in a residential aged care setting. It was the RNs who were seen as the accountable entity and the one person that staff felt they could go to for decisions, for support, and for guidance in their work. It was their influence in care decision making that came to the fore. The consonance in the research of the notion of an accountable entity was seen in the literature relating to RN leadership. There was also a product of accountability where responsibility was assumed for the choices made (Barbuto et al., 2014; de Waal & Sivro, 2012). This expression was representative of a servant based leadership modality where the work environment was about 'serving others' rather than the previously discussed distributed approach of collaborative shared decision making practices (Barbuto et al., 2014; de Waal & Sivro, 2012).

The experiences shared in many discussions was the ability of the RNs to influence and lead a team, and intuitively know when they were needed in a particular area of the setting. Collectively, the group of participants discussed this notion in relation to the reliance and dependability of the RN, the distinct knowing when things were not right and the reassurance and guidance in the provision of care surrounding the clinical care decisions made. For some EENs the power indifference seen within these experiences provided a level of anxiety, of reluctance to share the problems and of a notion of wanting to be engaged and involved in the decisions being made. This power indifference is discussed in the literature in the role ambiguity and confusion that resulted specifically within the role of the EEN (Jacob et al., 2013; Kenny & Duckett, 2005). Historically, nursing is a team based approach in the residential aged care setting, with care provided by a variety of clinical care

staff, each scaffolded to a defined scope of practice and yet all interlinked to fulfil care provision requirements to residents. This interlinking of roles was identified in the research. The influence each clinical role expounded to the next role was important.

The research participants outlined the need for the leadership role of the RN to have the ability to enable a team and to be collaborative in the leadership role. These are areas within the research that outlined the wariness of staff, the cautious guarding of territories or preference to work with one RN over another. This articulated the fine balance for the RNs in creating an environment for staff that enabled a collaborative approach in care delivery to be achieved often through a subtle influence seen, heard or felt from the role of the RN. The fine balance of leadership adding further complexities to the already complex leadership role of the RNs. According to Kanter (1977), a subordinate's ability to access empowerment structures within an organisation is often dependent upon their supervisor's ability to access empowerment themselves.

The presence of the RN was, in itself, viewed as a reassuring note to clinical care staff. Reassuring in the sense that they were present, responded to calls for assistance, and able to answer the questions or seek the advice or the clinical support required. The concept of being watched provided a perception of supervision, one of security for some and of caution for others. Kanter (1977) discussed the concept of power in organisations in two ways, the first formal power exerted through position and the second informal power that is derived from the quality of alliances and relationships with people in the organisation. It is often the informal power of the individual in the residential aged care setting that influenced the care and decisions surrounding care in this context (Chenoweth et al., 2010; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006; Yun-Hee et al., 2013).

8.3.3 The Driver of Teamwork

The concept of teamwork was demonstrated as positive and at other times a negative concept in the leadership role of the RN. Teamwork was described as a collaborative venture between the RNs, the EENs and the UHCWs. Teamwork was seen as a key characteristic in the literature in the implementation of resident-centred

care alongside strong leadership and collaboration (Brownie & Horstmanshof, 2012; Chenoweth et al., 2010; Yun-Hee et al., 2010; Yun-Hee et al., 2013).

The literature identified with teamwork as the ability to work together, communicate, and motivate each other to provide care (Miers & Pollard, 2009; Perrin et al., 2015; Weller et al., 2014). This concept of teamwork was seen to work well on the whole. A dissonance was noted in the research findings where conflict and disillusionment appeared between staff cohorts. The participative team approach was outlined in many narratives sometimes in a positive light and at other times through a level of frustration where elements of individual control, of direction and of potential for poor communication arose. This participatory team approach is seen in the literature where effective communication patterns and team participation are seen as facilitating self-organising systems that produced better resident outcomes (Anderson et al., 2003).

The research determined the understanding of this teamwork was successful when balance was achieved in the workplace between staff and in the quality of care provided. This is further supported in the literature through the aged care study conducted by Forbes-Thompson et al. (2006) that identified that staff members believed that nursing leaders made decisions without the input from other staff. The study indicated that further research was required in understanding how staff members perceive this leadership in work teams (Forbes-Thompson et al., 2006). This research has shown that the leadership role of the RN is dependent on the team and on the information obtained and that occurs through the level of dependence and trust the staff have in the RN as leader. The notion of teamwork in this essence extended to include the broader team in which the RN communicates and works with as part of the team. This required the assistance and close collaboration of a broader multidisciplinary team: a team that consisted of the staff, doctor, allied health professionals, the resident and their family.

It was through teamwork that the interactions with people that the RN gathered the required information to make appropriate decisions surrounding care provision. This notion of rapport with everyone was a concept of an idealistic nature and one that was not realistic of all situations. The leadership role of the RNs ideally was required to create and maintain positive relations with the management of the

organisation and also with peers. The residential aged care setting is a complex environment with known limitations within the fiscal resourcing requirements (Angus & Nay, 2003; Hughes, 2011; Segal & Bolton, 2009). It was in the sub categories of knowing the people and in the driver of teamwork that the requirements needed that provided the RN with the essential strategies required for planning care or in the delegation of care to other team members occurred.

Teamwork and the complexities in this paradigm appeared when learning more about understanding the approaches and domains of the leadership role of the RNs in working together as a team in the setting. It was about the day-to-day operations and the staff interactions that occurred. Importantly it was also about the responses received, the understanding of the leadership role of what approach to embark on and then in the application of this in practice. The staff expressed a desire to have a level of autonomy in their role. The combined clinical leadership in a distributed and collaborative manner emerged. One of the sub categories in this was in the sharing of information and the communications required in the decision making process.

Teamwork was also seen in the actions taken by the RN that was noticed and recognised by other staff. This teamwork intricately linked with knowing the people and knowing what happened in and within teams in defining the 'what is' of the leadership role of the RN. What was obvious in the narratives was that the teams were familiar with each other, small and defined, with RN leaders and their attributes well known to staff. For the majority of participants there were positive comments about the RN leadership and teamwork. The demonstration of a more distributed model of leadership appeared. This distributed model was based on the ability of the RN leader to encourage, inform and engage a team in the work require (Dearmon et al., 2015; Stout & Weeg, 2014; Tomlinson, 2012). The staff expressed the need to be heard, understood and engaged in decision making processes all within the clinical domain of providing care to residents.

The sharing of team information appeared as a vital component of the leadership role and was identified and understood as a communication source in teams, one individual to another. It appeared in the formal structures such as the staff handover of key information at the beginning and end of a shift. It was this

notion that further defined the RN's leadership role, its complexity, its need for ongoing support and guidance in creating and sustaining work teams. It was the reliance on the teams to communicate changes, or the subtleties that were noted in a resident, to the RN. Kanter's (1977) theory of organisational behaviour was evident in the outcomes that have emerged with the transparency and performance of the RN determined through the communication, the power balance and the influence of the RN with individual staff, and more broadly the team in the residential aged care setting (Kanter, 1977, 1981).

Through Kanter's theory of organisational behaviour (1977) the notion of formal and informal power relations was evident. The transparency and performance in the role was determined in the communication, the power balance held and the influence on the staff within the team (Kanter, 1977, 1981, 1994). The notion of the RN as a formal leader in the setting and the commonality of the EEN as an informal power base with leadership responsibilities in units in the residential aged care setting of the hostel and dementia care areas were identified. The need for a balance or balancing force in the power bases held or assumed in the team were key areas outlined. From a broader governance perspective the role of the RN was seen as the go to person, the one where decision making occurred, and the literature concurred with this finding (Anderson & Reuben, 1998; MacPhee et al., 2012; Supovitz & Tognatta 2013). It was the RNs that informally held the power balance or in some settings it was the EENs that formally held the position of leader. This added a complexity to the domain of leadership and one where Kanter's (1977) theories relating to organisational behaviour came to the fore. This balance was a key parameter in the driver of teamwork in the setting.

The practicality of nursing-oriented leadership was seen with respect to the clinical area of work with decision making capacity in line with clinical needs, staff relations and organisational capacity (Castle & Decker, 2011; Cummings et al., 2010; Stanley, 2014; Swanwick & McKimm, 2011; Walker et al., 2011; Williams, 2011). The categories and subsequent sub categories linked with the distributed leadership theory of inclusivity in decision making in teams. This distributed, yet also transformational approach to leading within a setting was idealised by clinical care staff participants who sought engagement in teams, autonomy in the cares provided and acceptance and inclusion in the decision making process. The literature

concurs with the distributed leadership approach providing avenues for staff to be encouraged, informed and engaged in a team in the act of doing the work required (Dearmon et al., 2015; Stout & Weeg, 2014; Tomlinson, 2012). The ability of a team and a leader to capture the essence of a formal leader with the drive and the ability to distribute or delegate to those to enact what was required for a resident was seen in the research and in the literature as important aspects in the leadership role of the RN (Asencio et al., 2012; Bergman et al., 2012).

The clinical care staff identified that staffing should be based on the right person for the right job. However the narratives determined that what this really meant was dependent on individuals and on the team and their ability to work together. Clinical leadership in the residential aged care setting emerged and was identified to be about care and care decisions and how the RN engaged with the team to meet shared visions, resident care and quality outcomes (Howieson & Thiagarajah, 2011; Stanley, 2008). The notion of clinical leadership that emerged in the leadership role of the RNs had similarities to the transformational/relational and distributed theories of leadership and again articulated the necessity for greater than one person's involvement in decision making processes and highlighted the need for clear and consistent communication channels in care teams (Berson & Halevy, 2014; Stanley, 2014; Walker et al., 2011; Wilson et al., 2013). Discussion surrounding clinical leadership highlighted the complexity in team dynamics between staff groups and individual staffing cohorts.

Team dynamics and their role in the organisations culminated in how the team was shaped and what communication structures existed to support them (Bogue et al., 2009; Brennan et al., 2012; Trus et al., 2012). The RNs identified the complexities and difficulties that arose in their role, the leadership required to address situations involving staff and sometimes families and residents. There was further acknowledgement that not all RNs had the same experience, the same ability to problem solve or to understand the complexity of leading a team in the residential aged care setting. What was identified and supported from within the literature was the known ideal that the RN holds the accountability, knowledge and ability to make decisions that guided care and lead the team in resident care delivery (AHPRA, 2015; Moloney et al., 2016; NMBA, 2007, 2016b, 2016c).

The research also identified the challenges that presented in teams particularly from the team dynamics. The research concurred with the literature on the expanding role of the UHCWs, the responsibility placed on the RNs in care planning, coordination and complex needs, and the role disenchantment seen in the role of the EENs as they remained in the centre of two expanding positions (Jacob et al., 2013; Tuckett, Hughes, et al., 2009). The arising concept of clinical leadership was a positive step in learning more about the leadership role of the RNs in the residential aged care setting. A key concept requiring greater review was identified in the dissonance that was uncovered in the research in the imbalance in roles and the delineation of work roles in the setting. This is further supported in the literature in discussions surrounding team dynamics and the power struggles that developed (Jacob et al., 2013; Kanter, 1977; Kenny & Duckett, 2005). There appeared a need for a level of ownership and satisfaction in the work being undertaken by clinical care staff and the leadership from the RNs to enable this to occur.

A dependability became apparent in teams with reference to their reliability, the trust the RNs were expected to instil and the ability of the RN to '*be there*'. The RN was encapsulated as the specialist, the go-to person when staff felt unsure, when advice was needed, or when the health or the well-being status of a resident changed. It was this reliance and dependability that resonated and is discussed within many of the concepts that have emerged. Central to the staff was the ability of the RN to know and understand, and to communicate, assess and provide decisions on care and clinical practice requirements.

The RN was seen as the decision maker, the coordinator of care, documentation, and communication. The interviews collectively unveiled a role that involved the liaison with staff, with management, with families and with allied and medical health care professionals. From the perspective of caring for high care residents in the settings, the RN was seen as the role where the assessment of medications and their context was completed. It was the staff understanding of the role of the RN, its complexity and its ability to respond that echoed in the understanding of the leadership role that evolved. It was these principles that developed in relation to *working together* and *collegial friends*.

The concept of the better the team leader the better the team implied feelings of security or well-being and of the communication chains that filtered information throughout the organisation. If a positive construct and communication was present with RNs who understood their role and their leadership capacity a more positive team approach became apparent. The key to this construct was the communication that occurred.

The construct of teamwork, developed through the ability to work with staff, seeking staff feedback and input into care decisions, was critical. It was also the reassurance provided by the RNs to the UHCWs and the EENs that the decisions made were to improve a situation and provide the comfort and reassurance to both staff and resident. These sub categories aligned with the principles relating to clinical leadership and working in teams. Through the exemplars provided in the narratives of the clinical care staff, clarity was gained in understanding the leadership role of the RN through the carriage of the ability of the team to work together. This carriage was a fine balance requiring the respect of staff and the opinion of all in the decision making process. It was this concept of knowing the people that influenced the leadership role of the RNs.

8.3.4 The Link in the Communication Chain

Communication in the team was complex however required rhythm, expression and a tempo to work. Through the communication portal between UHCWs, the EENs and the RNs, the combined effort either made the day a success or led to miscommunication and a *'bad day at work'* as aptly put by one EEN participant. Working with EENs and UHCWs identified the importance of communication between staff for the role of the RN. This communication was a balance that when working provided an open portal for the discussion, dissemination of information and for successful resident care decision making.

The experiences displayed and discussed were of a positive nature that openly discussed the ability to *'have a good relationship and rapport'*. To achieve this rapport and relationship a key concept was in the realms of communication. Communication with staff, residents and families, was a complex domain. In itself, it was a web of many dimensions, each critical in the leadership role of the RNs in

the residential aged care setting. The literature concurs with the research as communication was viewed in all areas of leadership practice as a key ingredient, an essential concept in the basic foundations of the practice of nursing (Acree, 2006; Avolio & Bass, 1999; Dignam et al., 2012; NMBA, 2016b; Stanley, 2014). The nuances to the communication required in the leadership role of the RNs have been articulated by the participants. It could be said that the communication from, and within the role of the RNs was the catalyst for care decisions, for care coordination and for the documentation of care requirements from both a clinical and regulatory perspective.

There were so many areas in the sub category of communication, yet as individuals it was in the basic communication structures where messages were conveyed, understood and enacted that were most important. It was from communication that a resulting action would occur, and it was this result that proved either positive or negative with sometimes unwanted or ill received consequences. The leadership role of the RN was not just a matter of making people happy, rather a complex process of listening, hearing, absorbing and analysing the information provided. The literature identified that the need to communicate without fear of repercussion was important and the need for accurate and objective information was key in transferring information relating to a resident's health status (Arnold & Boggs, 2013; Forbes-Thompson et al., 2006; Garon, 2012).

This leadership was then enacted in the development of a suitable response, a plan of care or a sensitive conversation with a resident, a family or with staff. The literature generically on leadership and more specifically the leadership of a RN agreed with this concept (Hurley & Hutchinson, 2013; Miers & Pollard, 2009; Reeves & Macmillan, 2010; Rokstad et al., 2015; Salanova et al., 2011; Scott-Cawiezell et al., 2004). The literature identified with the large role of the RN and the tasks associated with it, and in the coordination of the team in both care provision and the communication of events to a central point (Miers & Pollard, 2009; Reeves & Macmillan, 2010; Scott-Cawiezell et al., 2004;). The literature spoke of the generic importance of communication and this research identified the explicit areas of communication the clinical care staff identified as vital (Anderson et al., 2003; Arnold & Boggs, 2013; Berson & Halevy, 2014; Castle & Decker, 2011; Garon, 2012; Perrin et al., 2015). These areas specifically inclusive of the nuances in the

residential setting of a visible presence and a respected and accountable RN to go to, in the event of a situation or event arising where assistance was required.

The clinical care staff identified the communication process, the communication act, and the result of both good and bad communication in practice. Resonating with the leadership role of the RNs was the notion of communication, often therapeutic communication, sometimes personal, however overwhelmingly a professional presence in both the written and the verbal nature of what was and wasn't said. There are many anecdotes and situations described by the clinical care staff that related, responded and reinforced the need for good communication. The literature discusses these concepts specifically the need for people in organisations to have good communication skills, the ability to work in teams and the teamwork and leadership to provide resident care and meet organisational improvements (Begley, 2009; Bowers et al., 2011; Davies, 2013; Garon, 2012; Tyler & Parker, 2011). Communication as it was discussed in the research and further supported in the literature assured a consonance with the narratives and concepts that have arisen. The research also concurred with the literature that the complexities involved in the art and science of communication can result in power differentials in teams, miscommunication and ineffective communication as personal, individual responsibility is required in the conveyance of messages (Anderson et al., 2003; Berson & Halevy, 2014; Castle & Decker, 2011; Johnson & Ezekielian, 2014; Kadu & Stolee, 2015). Seeking these moments to share was important, as communication was an aspect of the leadership role that couldn't be separated. Yet communication occurred individually with nuances and differences noted from RN to RN.

The reality in practice of how in a residential aged care setting clinical care staff communicated resident changes from staff to staff, from shift to shift, and from internal to external entities became clearer as the interpretative analysis progressed. The handover was identified as a system of reporting on residents by variance. Although information was relayed it was not necessarily through first hand discussion. More often than not communication occurred in relays, from one individual to the next, to a diary or journal and again to another staff member. When communication was not direct from one person to the next the complexities of care provision and team unity had the potential to disappear. A secondary reporting of handover from one UHCW to another was based on the care provided, the issues or

concerns that arose from their perspective and in the social care requirements heading into the next shift of care provision.

A disconnect presented in the communication of both care requirements and resident status in the residential aged care setting. For staff this appeared a normality, a daily regime of reporting and communicating often through diaries or third person relayed messaging. The narrative collected and highlighted further the leadership role of the RN and how their role formed a key component of understanding this communication process and the resultant leadership the RNs demonstrated. It was the RNs that led the team, were accountable for the practice that occurred, and were the responsible entity for communication with families, with medical officers and with the staffing teams providing care.

This communication stemmed from the necessity of knowing information, yet prioritising the time available at shift change to communicate appropriately. It related to time management, to prioritisation of care coordination, and to seeking the most relevant information in the communication of a large number of residents within a short space of time. This discussion bears with it the understanding that the scope and communication of changes in a resident's condition occurs regularly. The literature outlines the context of the aging person, the increasing age of residents and the chronicity of conditions that many residents living in residential care settings present with (Baines et al., 2014; Bishop, 2013; Sonaware, 2015; Walmsley & McCormack, 2015). It was this increase in age and in care provision that further added to the complexities in communication. This complexity added to the information required to be handed over from one shift to the next.

Communication from the role of the EEN was significant as they provided the conduit from UHCWs to the RN. It was this bespoke communication chain that existed in the residential aged care setting that saw the EENs alongside the UHCWs in care provision. It was also the EENs alongside the RNs in care coordination and in the communication with and through the team. It was in this area that changes in a resident's conditions and in communication for assistance occurred. The research identified with the communication that occurred between the EENs and RNs as a predominantly positive communication trail.

Areas of role confusion or frustration emerged where the EENs had the understanding and knowledge to recognise the required intervention for a resident however did not have the required scope of practice to enact on the requirements. The need to wait for a RN to assess and plan suitable care was a source of frustration for some EENs. This concept is discussed in the literature in relation to the role confusion and role boundary limitations versus expectations that arose in the day to day practice of caring from the EEN role (Kenny & Duckett, 2005; Milson-Hawke & Higgins, 2003). This confusion was also an area where expectations from the role of the RN were based on staff ideals and not through a position statement of the role and capacity of the RN in the specialised area of aged care nursing. The need for a clear defined position statement was evident in this research to assist in the communication of the RN role and its scope and capacity.

The importance of the trust and respect and communication between the two roles was seen as a key contributor to the leadership role of the RN. The fine balance of bipartisan inclusion and respect and the need to communicate effectively was identified. The complexity in this communication seen through the disillusionment and role erosion experienced by EENs as they led a team in the delivery of care, but were excluded from the assessment and decision making process (Kenny & Duckett, 2005; Milson-Hawke & Higgins, 2003).

The concepts of equality, respect, and of how these interactions occurred was identified further through the categories and sub categories that emerged in the research. Understanding when it was, or wasn't appropriate to lead or to follow, a delicate balance established within the realms of open dialogue, observation of non-verbal cues and the assessment of written care plans and orders from the broader interdisciplinary health care team. The need in a team for both a leader and for followers was key in this concept and one shared from the literature (Hamstra et al., 2014; Kean et al., 2011).

The concept of balance between the role of the leader and the resultant followership that ensued was discussed by participants. The need to have a level of inclusion and yet the ability to trust and receive the required direction from the RNs was sought. The balance between the two was identified in the fine detail of the communications that occurred between the RN as leader and the clinical care staff.

Important in the communications was the engagement and level of interaction with staff. The engagement and socially constructed phenomena that is seen in the literature affirms these categories and sub categories with the ideal that 'leadership cannot and does not occur without followers' (Meindl, 1995, p. 331). It is this essence that sees leadership as a socially constructed phenomenon (Hamstra et al., 2014; Kanter, 1981; Kean et al., 2011).

The discussion thus far has outlined the importance of the people, the influence or the capacity to influence both at a staff and a resident level, the teamwork that is required and the sphere of communication that exists in each of these areas. In developing an understanding of the leadership role that evolved was the reality that each of these sub categories are intertwined, connected by many concepts, yet separate in others. Overarching these themes was the sub category of the RN as coordinator in the hierarchy of control.

8.3.5 The Coordinator in the Hierarchy of Control

The hierarchy of control in the residential aged care setting was a complex being. The complexity was seen through the organisational requirements, the legislative jurisdiction of care requirements that were mandated, the knowledge and implementation of cares in alignment with the complex funding models and the balance of staff in the coordination of these requirements. The literature concurs with these areas of complexity from the organisational to the legislative and operational contexts to the diversity in the areas that the RN is required to know, understand and enact in the leadership role (Aged Care Act, 1997, 2014; Angus & Nay, 2003; DoHA, 2006; Hugo et al., 2009). These areas raise concerns in a system of residential aged care services that currently faces difficulties in fiscal resourcing, staffing and within nursing recognition as a specialisation within practice (Castle & Engberg, 2008; Hodgkinson et al., 2011; Pearson, Schultz, et al., 2006). The research identified the complexities of the system that articulates in the decision making capacity of the RNs. This decision making capacity is led by the fiscal resources available, the ability to maintain compliance with standards or the staffing requirements needed to achieve a particular aspect of care. The literature concurs with this finding noting that the RN is often limited in their decision making capacity

as the daily care and completion of regulatory assessments overshadows the vision and voice of nursing leadership (Angus & Nay, 2003; Jeon, Glasgow, et al., 2010).

An assumption that appeared in the research was the need to recruit the right employees into the sector. The narratives openly discussed the need for aged care nursing to be seen and respected as a specialty discipline with other health industry colleagues with specific interests in palliative care, wound management and chronic illness (Hasson et al., 2008; Johnson et al., 2009). The literature concurred with this outcome and also outlined the expense to the system of staffing models and a growing need for the management of chronic illness, palliative care and dementia care (Abbey et al., 2006; Barbosa et al., 2015; Wong et al., 2013). The literature does not articulate the area of aged care nursing as a subspecialty (Cameron & Brownie, 2010; Dwyer, 2011). There was a noted dissonance between the desire from staff to be acknowledged and respected as a subspecialty yet the discussions at a government level identifying with areas of nursing practice where an increase in an UHCW workforce was noted (ABS, 2014; Chenoweth et al., 2010; Milson-Hawke & Higgins, 2003).

The research outlined the role the RN has in ensuring that compliance with the required mandatory aged care standards is met. The RN coordinated audits and delegated responsibility to clinical care staff in the collection of information relating to compliance standards. In this respect the RN was at the forefront of care delivery components that maintained a facility's level of compliance with the regulatory expectations of government agencies. The RNs understanding of quality improvement, initiatives and funding, or staffing requirements were negotiated to gain the required approval for changes in care practice. It was the RNs that the staff saw as key to making changes to the flow of care and to the maintenance of individual and collective staff satisfaction in the setting. This expectation of staff on the role of the RN was seen in the formal leadership role held by RNs in the residential aged care setting. The research identified the role the RN orchestrates in discussions surrounding increased documentation requirements to meet compliance standards, the questioning by families and the need to understand the health conditions, the approaches to palliative care and the ability to practice these. Research conducted by Venturato et al. (2007) discussed the difficulties and complexity of the role of the RN in the aged care sector that demonstrated a

consonance with the research findings. The RN role often caught within the system of caring and leading in an environment of restriction, prescribed through regulatory requirements.

The complexity seen from the role of the RN was one that saw the RNs responsible and accountable however one where career opportunity or advancement was not as explicit. RN advancement in the residential aged care setting often entailed specialist roles in funding, quality or management positions (Howieson & Thiagarajah, 2011; Jeon, 2014; Jeon, Glasgow et al., 2010; Jeon, Merlyn et al., 2010). RNs expressed the desire to advance in the clinical domain of caring for residents however opportunities in this space were restricted. The literature supports the desire expressed by RNs however also outlines that opportunities to advance in the clinical domain are restrictive and detracts the RN from the bedside, leaving the focus of care on areas of compliance rather than health and well-being (Angus & Nay, 2003; Bellis, 2010; Hughes, 2011). The result of a lack of incentives in career advancement further details the negative connotations that drive aged care and 'aged care nursing' and result in a sense of work in an environment where conditions are less, wages are less, and the profile of specialisation is low (Hodgkinson et al., 2011; Tuckett et al., 2011). This further added to the complexity of recruitment and retention in the workforce (Venturato et al., 2007).

One organisation demonstrated leadership in the role of the RN with the appointment of a NP across the settings organisationally. The role, a solitary role across all facilities in the organisation's jurisdiction, saw the NP conversing with RNs often remotely by phone for acute concerns relating to residents. The proactive nursing approach was seen in the clinics and regular site visits made through the NP role that allowed for wound assessments, referrals and decision making to occur independently and in a timely manner from the role of the RN. The support from RN to RN was also discussed in this context with the RN in a facility able to make contact with the NP in times of need. The ideals of a career progression pathway were discussed in this organisation however the reality of a sole position and the acknowledgement of the reality that no further positions would be likely added further to the negative construct of career advancement in the clinical sphere in the residential aged care setting.

The research outlined the dissonance in the ability of the RN to demonstrate the required leadership and the resultant career acknowledgement that coincides with the responsibility and accountability of the position. Efforts to increase the interest in attracting RNs in caring for the older person in residential aged care settings remains a key outcome of this research. It is vital to ensure that care requirements and specialisation in dementia, palliative care, chronic disease and elder care are initiated, sustained and improved according to contemporary practice in the setting (Duffield et al., 2011; Kleinman, 2004; Venturato et al., 2007). The sub categories are supported by the literature however the complexities of creating a system that enables progress and is supported through government and regulatory authorities requires understanding of the situation and the effect in application on the leadership role of the RN.

The understanding from the RNs of the limitations in career opportunity and in the heavy regulatory compliance matched with a limited pool of RNs in the setting, created a divide between the desire to care and yet the struggle to apply what was required as opposed to what was needed in practice (Chenoweth et al., 2010; Huntington et al., 2011; Tuckett et al., 2011). As an RN the ability to practice according to the needs of a resident, the scope of practice of a RN and the expressed desire of the resident were important.

The retention of RNs in the setting was viewed by participants as problematic particularly from the role of the EENs who were required to step into a leadership role each time an RN resigned. It was the EENs that sought stability in the setting, and who sought to work with the RNs in a collaborative way. It was the EENs that expressed the difficulty with ongoing staffing changes, with limited opportunities for the RNs and their resultant resignation and move to areas in nursing where greater opportunities existed. The understanding of limited career opportunities, a lack of recognition and an inability at times to practice to the full extent of the defined scope of practice was deemed by the RNs as self-limiting, unrewarding and professionally damaging (Chenoweth et al., 2010; Huntington et al., 2011; Tuckett et al., 2011). A noted expression from the RNs saw the desire to work with people as they aged however the ability to practice effectively was limited. The literature concurs with the need to increase the attraction of aged care nursing, to ensure that care requirements and specialisation within dementia, palliative care, chronic disease and

elder care are initiated (Duffield et al., 2011; Kleinman, 2004; Venturato et al., 2007).

The historical undertaking in Australia of caring for people as they aged is inherently linked with the social health model and relates to seeking alternative housing accommodation for the aged (ABS, 2014; DoHA, 2012; Ibrahim et al., 2014; Kadu & Stolee; 2015; King et al., 2013). The story of residential care is linked with ongoing aged care reforms with the aging in place models however the premise of care in the aged care setting remains aligned with the idealistic medical model of care (Bishop, 2013; Caspar & O'Rourke, 2008; Walmsley & McCormack, 2015). This model applies to aged care policy initiatives, and has in itself seen an increase in residents being cared for in their own rooms in the residential setting. Simply, this response corresponds with early release programs from the acute hospital system, or the management and coordination of palliative care requirements in the residential aged care setting (Abbey et al., 2006; Barbosa et al., 2015; Bellis, 2010; Martinson & Berridge, 2014; Wong et al., 2013).

Changes to the parameters of care of the different levels of clinical care staff have been initiated as part of the ongoing reform process in Australia. These changes relate further to the increased capacity of the UHCWs, the status quo in the role of the EENs and a greater accountability and auditing role for the RN. An area expressed in the research from clinical care staff was the introduction of the UHCWs undertaking medication administration. This skill requires a UHCW to know what medication is needed, when, why and what implications or health benefits or interactions may result. The UHCW role is educated locally in their facility on the skill of medication administration however remains reliant on the RNs for all other aspects of the medication, its effect and complications. This aspect highlights the need for the RNs to have the understanding of the team and the complexity in care provision provided by the team and the resultant level of accountability.

The sub category of the RN as coordinator in the hierarchy of control elaborates the connection with the existing sub categories of knowing the people, being a person of influence, the driver of teamwork and the link in the communication trail. The complexities of the setting and the environment of the aged care system in Australia coinciding with the compliance standards that are

mandated required a diligence from the role of the RNs (Hughes, 2011; HWA, 2012; King et al., 2013). This diligence was seen in the understanding of what the requirements of the setting entailed, that is, the leadership to enable the compliance standards to be achieved, and the application of these in day to day practice. These categories were further supported through the report conducted by the Productivity Commission (2011a, 2011b) that conferred that there is a definitive need to review workforce shortages as the aged care workforce will only continue to expand given the growing aging population in Australia.

The emerging themes identified in understanding the leadership role of the RN were seen to incorporate sub categories in the hierarchy of control. It was the hierarchy of control that the RN was required to understand, to work in, and to guide a team of clinical care workers in the provision of resident care. The changes to the setting, the greater complexity seen and the need to provide the guidance and education to staff were critical as it was these areas that enabled the team to have a greater understanding of the complexities of the aged care system and the ongoing system of discussion, reform and increasing regulation that prevailed (Hughes, 2011; HWA, 2012; King et al., 2013).

The leadership models presented in the literature in the residential aged care setting focus primarily on achieving tasks, delegating cares and problem solving that enabled meeting areas of care, compliance and regulation, often within staffing models of great diversity and numbers (Bellis, 2010; de Waal & Sivro, 2012; Swearingen, 2004). The RNs expressed the desire to care and the desire to lead. At times a restriction occurred in the ability of the RN to perform due to the control and regulation that existed in the organisation. This control and regulation was seen as an inhibitor to effectively leading a team. This restriction presented the notion that the leadership style present in the settings no longer was desired as staff sought the inclusion in care decision making, an autonomy in the work conducted, and the ability to work as a collaborative team.

The EENs identified an increase in responsibility in the setting with coordination roles in the hostel or dementia-specific environments (Jacob et al., 2013; Kenny & Duckett, 2005; Milson-Hawke & Higgins 2003). This increasing responsibility was also seen as an inhibitor where scope of practice limitations

restricted the ability of the EENs to perform to the level required in these specific areas of care. Interestingly, the role of the UHCWs was seen as an area where skills and the role performed had significantly increased with the ability of the UHCWs to administer medications, perform observations, complete documentation relating to behaviour charts yet assume limited to no accountability for the actions completed. This placed the RNs in a situation of greater responsibility yet limited scope in monitoring what action care was performed. This required a knowing from the RNs in the leadership demonstrated to set practice boundaries with each of the staff cohorts to ensure that care was provided both as needed and as prescribed. For some RNs this meant that they were specific in their requests for which staff completed which task. It was the reliance, the dependability, and the communication in and within the teams that remained key and it was how this detail of the day to day work was completed that effectively or negatively affected teams of clinical care staff. The ability to achieve this parameter well according to the literature allows for teams to be enabled, motivated, positive and autonomous in areas of practice pertaining to caring for the older person (Anonson et al., 2014; Chenoweth et al., 2010; Pearson et al., 2007; Yun-Hee et al., 2013).

Kanter (1977) describes the two specific empowerment structures in organisations as the structure of opportunity and the structure of power. It is these two different sources of power that create the culture, set the scene and harmony in a workplace, or one that creates conflict and chaos, and interferes in a negative manner with the leadership and consequently the care provided to residents (Caspar & O'Rourke, 2008; Kanter, 1977, 1981, 1982, 2010, 2011; Spence-Laschinger et al., 2010). This research outlined the desire by the RNs to have the RN role in the residential aged care setting recognised as a specialty area of nursing, to have distinct profiling of the position and career pathways through education, mentorship and experience. The expression from the RN participants was for greater opportunity and career pathways in palliative care, dementia care, chronic illness management and gerontology nursing practice. The concept of formal leadership training was acknowledged by the RN participants and the expression was that such training to date was theoretically based and not derived in relation to the individual, the practice setting and the mentorship that was felt to be needed. It is these aspects in the research that created a dissonance between the participants and the literature.

The Australian government perspective identifying in the literature that only limited numbers of RN aged care staff engaged in education (King et al., 2013). A further dissonance was noted in the implementation of the LEADS project with RN staff expressing an acknowledgment of the leadership framework however in practice outlining that the framework pertained more to the hierarchy of management and not the coalface clinical leadership the RN saw in their role (HWA, 2013). This dissonance an area of understanding that requires greater intervention and discussion and one where the application in practice is also impacted.

8.4 CHAPTER SUMMARY

This chapter has discussed the category of understanding the leadership position in the RN role in the residential aged care setting. The initial discussion included an introduction to the category of understanding that emerged from the narratives. This understanding has been presented through discussions surrounding each of the sub categories. The exploration of the voices of aged care staff in residential aged care settings identified a complex process involving the need to have knowledge of and an understanding of these sub categories identified in the RN leadership role. This interlinking of sub categories outlines a web of interactions and connections between both the categories of understanding and of the application of leadership in practice in the RN role in aged care. The leadership is seen as an orchestration of the consonance or dissonance of the guidance provided and direction established in the day to day care delivery through the role of the RN. This leadership has been identified as both an individual and collective nature. When orchestrated well this expression affects the teamwork and the base derivative of the 'what is' of the leadership role of the RN. This category of application is discussed in more detail in Chapter 9.

Chapter 9: The Application of RN Leadership in Practice

9.1 INTRODUCTION

The outcome of the descriptive analysis of the narratives formed the underpinning concepts identified in the interpretative analysis phase where the emergence of the application of leadership was identified. It was about the RN, their leadership and then collectively about the broader aged care team. The determination of the understanding of the leadership role has been discussed in chapter 8. Chapter nine discusses the application of RN leadership in practice in section 9.2 and the sub categories that present. The application was revealed through a process of firstly breaking each of the concepts into smaller components. The steps involved identifying further areas of clarity from the narratives and again linking these to the concepts established in the descriptive analysis phase. This provided a cyclical process of uncovering and delving further into the narratives.

9.2 THE CATEGORY 'APPLICATION OF THE LEADERSHIP ROLE IN PRACTICE'

The category of 'application of the leadership role in practice' was specifically related to the RNs performance in their role, their knowing and their doing, in the provision and coordination of care. Five sub categories of application in practice emerged. These five subcategories were:

- the ability to lead,
- gaining staff trust and respect,
- influencing care and decision making,
- being focussed on care, and
- navigating regulation and legislative control.

The terminology of 'application' was defined as the ability to apply practically to problem solving and innovation in the human, physical, fiscal and psychological command of the residential aged care setting. It was this critical thought process in action that created the underpinnings of 'application' in the

leadership role. To understand the sub category of the application of the leadership role of the RN in aged care requires an introduction. The sub categories include:

1. **The Ability to Lead –** Encompasses the direction required in the coordination of care and care decisions, the liaison with families, with doctors and with visiting allied health professionals. The provision of support to staff, the care planning and the care evaluation that links between and within the teams, the stewardship of staff dynamics, conflict, mediation and resolution within operational components of the everyday work environment.
2. **Staff Trust and Respect** – The approach of knowing the RN, feeling comfortable with the decisions made, having faith and support in work teams, being available and responsive, and the subtleties in knowing a supportive hand is near.
3. **Influencing Care and Decision Making** – Exerting positive control and effect in teams, managing informal power balances that exist or develop, leading decision making capacity and holding responsibility for the decision making and the influence within the type and style of care provided.
4. **Focused on Care** – Provision of the balance between what the resident needs and what is practically possible in care provision. The desire to provide and guide decisions, be inclusive, provide guidance, education and support to staff.
5. **Navigates Regulation and Legislative Control** – The legislative balance between documentation requirements, the resident, clinical reviews, the quality audits and the regulatory audit and compliance management that the RN fulfils.

The sense of knowing that the RN was there, and that the required action occurred when needed was important. This application of leadership in practice provided a covert, subtle approach, as a sense of being that occurred often quietly and modestly in the day to day practice of the RN.

9.2.1 The Ability to Lead

Team work was an essential ingredient in the working day of the RNs. In establishing a greater awareness of the leadership role and how in teams this was successful, was important in the application of the leadership required of the RNs in providing a team approach to care delivery. The perspective from participants on how the team was facilitated, how it was guided and the level of input and discussion required was essential. The complex web that was created, planned and

implemented in this leadership role was dependent on the concepts and the areas of practice that emerged. These areas of practice in the application of the RN leadership role were not isolated but linked correspondingly to the care provided, to the staff, to the resident, and to the work environment.

The recurring concepts identified in this research focused on the people and the care provided within the sub category of leading and following and the focus on care provision. Underwritten in these concepts was teamwork and communication. This was demonstrated sometimes in the positive and other times as a negative in the leadership role of the RNs, from a system that offered ongoing challenges through reform and restriction. The discussions in the literature surrounded the ability to achieve success in leading teams and outlined the requirement that to enact leadership the RN must be understood, empowered and have the autonomy and authority to practice (Bogue et al., 2009; Brennan et al., 2012; Trus et al., 2012).

The inclusion of staff in the decision making process was seen as a positive relationship to the desired leadership role staff expected from the RNs. Linked with this concept was the identification and knowing that the RNs held responsibility for both the decisions made and the attributable outcomes. Staff expressed the accountability of the RNs as one of reassurance and comfort for staff in the clinical care team. This application of leadership and the interconnected components presented an expectation from the leadership role of the RN to be present and visible in the setting. The literature concurs with this concept with the aged care work environment encouraging staff to make decisions and coordinate care priorities based on what needs to be done (Ascencio et al., 2012; Havig et al., 2011). The visibility and presence of the RN increased the sense of security amongst staff that guidance, assistance and decision making was occurring.

The ability to lead a team was also seen in the leadership role of the RNs as a responsible entity, a reliable contact for problem solving, the decision maker and the communication network provider for the residential aged care setting, for the staff and for the organisation. This responsibility and accountability is seen in the literature and discussed by Damschroder et al. (2009) as the need for leaders to have the responsibility of engaging staff, and in mentoring and influencing attitudes and

beliefs. The intricate balance provided by the RNs encapsulated this responsibility and accountability and was identified in this research.

A dichotomy to this cohesive team appeared and is noted in the statement from an EEN participant *'I don't think they get it, we are all here together.'* The ability to work together for a common goal was disputed in this statement. A statement arising through perhaps a miscommunication or an overarching authoritative approach from one RN, resulted in a sense of disenchantment or lack of respect or trust for all RNs. The action or application of the leadership enacted in the decision making capacity, the governance in care decisions and the involvement of the team, was a complex process of negotiation and mediation. This process was seen as greater than just the process of making decisions and conveying them.

The application was seen in the way the decisions were made, the way the team was involved and in the way the information surrounding these decisions was communicated. Decision making and the influence of the leadership role of the RNs was further supported in the literature where discussions prevailed on the decision making process, at times using an authoritarian approach and other times an inclusive collaborative venture (Avolio & Bass, 1999; Bamford-Wade & Moss, 2010; Cummings et al., 2010; Doody & Doody, 2012). The differences which appeared between staff and considerations were noted in relation to the experience and capabilities of the individual clinical care staff involved and the corresponding level of experience of the RN (Avolio & Bass, 1999; Bamford-Wade & Moss, 2010; Cummings et al., 2010). The individuality of decision making was clear and audible, the individualisation discussed, and the application of leadership in practice prescribed in the reality that we all think, act and lead differently. As individuals that receive a message, for some it will seem appropriate, for others perhaps harsh and for some, an insult on their being (Anderson et al., 2003; Donohue-Porter, 2014; Ibrahim et al., 2014; Jeon, 2014; Scott-Cawiezell et al., 2004).

In examining the leadership role and the way a team functions, its premise of understanding the *'way things get done around here'* came to the fore. It was this comment articulated by both an RN and an UHCW that idealised the concept of an application in leadership approach. This statement indicated the culture in a team, the effect that the leadership had on the team and the way in which work was

conducted. The culture noted in the residential aged care environment identified successful work teams occurred in a positive and receptive environment. The complexity of the setting, the regulation and statutory obligations that drove practice, and the fiscal resourcing and attributable funding parameters that ensued, were clear in the research and supporting literature (Dwyer, 2011; Pearson et al., 2007).

Staff identified with working in teams however the identification of nuances in the team and of individual versus professional obligations arose (Dwyer, 2011; Pearson, 2011). The leadership role of the RN was seen as a complex role with staff, power relations and limitations in clinical career opportunities prevailing (Kanter, 1977, 1981). The accountability and responsibility were seen as a key construct in the leadership role and one where the application of leadership was demonstrated. This application of doing the work, completing the tasks and more collectively the act of communication and decision making, was key in the construct of leading and following. The importance of this statement inherent in understanding that the leading that occurs in the team has an effect on the resultant following that proceeds.

The act of leading and following was key in the construct of a team approach to care delivery. A team with a culture of progression, a culture of respect in staff, and a culture of best practice standards was able to enact good resident outcomes and staff satisfaction. It is often the informal power of the individual in the residential aged care setting that influenced the care and decisions surrounding care and the work culture that was present (Chenoweth et al., 2010; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006; Yun-Hee et al., 2013). It was the opportunity for staff to have career opportunities and a sense of empowerment in the work completed that created the culture and set the scene in a workplace, or one that created conflict and chaos, and interfered in a negative manner with the leadership and consequently the care provided to residents (Caspar & O'Rourke, 2008; Kanter, 1977, 1981, 1982, 2010, 2011; Spence-Laschinger et al., 2010).

Not all teams displayed a culture that represented a positive approach. In reality the ability to set the tempo, establish the relationships in affecting staff change, in promoting a culture of positive staff engagement and a culture of best practice standards, was seen as a continual drive and ongoing improvement process. This was a drive to overcome '*the way things get done around here*' and a drive to

engage staff through the application of the leadership role in practice delivery that was led by the RNs. Organisational culture became evident in both the research and the literature with the notion of work being completed to a level of compliance rather than to a level of contemporary best practice (Cummings et al., 2010; Martin & Waring, 2013; Spence-Laschinger et al., 2010).

Reform and change in residential aged care nursing was identified as an ongoing pursuit in the political landscape where the need for staff to develop methods to manage and work in the setting was at the fore. The application of change was a key ingredient in the clinical environment with positive staff engagement and satisfaction resulting, or a negative connation of resistance, negativity and non-compliance (Cummings et al., 2010; Martin & Waring, 2013; Spence-Laschinger et al., 2010). The creation of cultures in this essence restricted staff access to resources, information, support and opportunity, all then rendering the employee powerless in the residential aged care setting (Cummings et al., 2010; Martin & Waring, 2013; Spence-Laschinger et al., 2010). This undoing of practice further disempowered clinical care staff and undermined the RNs and their potential and desire to care and effective lead the team (Kanter, 1981, 2011; Spence-Laschinger et al., 2010). In practice, a disempowering culture was one of the de-motivators of aged care staff in leading the team particularly where decision making was ‘undone’ by the existing norms and structures of the aged care organisation (Cummings et al., 2010; Spence-Laschinger et al., 2010).

Staffing or the choice of staffing came with complexity and challenge however the matching of staff to an environment was key to the success of the team. The experiences shared articulated the leadership role of the RNs was about the team however also indicative of the personalities and approaches of the staff in these teams. The leadership identified also presented that of a shared arrangement in and between staff where responsibility was shared however accountability remained with the RNs. The ability to lead was seen in the application of the leadership role and was further viewed as a complex domain of firstly knowing the parameters identified in the understanding and then in the application of these in the day to day interactions that occurred. This application was described as more complex than a simple linking of the principles of understanding to one of applying them in actual practice.

The linking of both the understanding and the application of the leadership role demonstrates a link between the two constructs. This interlinking of both having knowledge and the ability to apply leadership ideals are key ingredients in the 'what is' components of the RN leadership role. The application of this leadership changed depending on the RN the staff member worked with. This decision making power, often covertly utilised, however at times of great need an authoritarian lead was seen. For staff it was in the knowing that the RN was there, often in the wings, making decisions, guiding care and allowing the application of their leadership to drive and respond to resident and staff situations.

The concepts of responsibility and accountability were strong and heard loud and clear from the voices of the clinical care staff. Kendig and Duckett (2001); Tuckett et al., (2011) and Yun-Hee et al., (2013) discussed the hierarchical traditional structures portrayed in a strong medical model domination that often was seen to repress nursing leadership at the frontline of care in the aged care setting. The literature asserts that the typical leadership historically seen in Australian residential aged care settings has been authoritarian in nature where decisions and communications occur bureaucratically from the top down (Bellis, 2010; Jeon, 2014; Jeon, Merlyn, et al., 2010). Historically, leaders have provided instruction to what has been a largely unskilled or semiskilled unregulated workforce, rather than working in teams where clinical decision making is more of a team process that also incorporates the resident (Bellis, 2010; Forbes-Thompson et al., 2006; Hodgkinson et al., 2011). These areas place restrictions and demand on the role of the RNs, seen and heard in the outcomes of this research. These outcomes are a derivative of the lessons and understanding of clinical leadership and in the application of this leadership in the residential aged care setting.

The clinical care staff expressed a desire to work as a cohesive team, with mentorship and leadership from the RNs, however it was the EEN participants that added a dichotomy to the experience. It was from the role of the EENs where an understanding of the need to be inclusive and to engage staff in decisions was apparent. It was also within this group of staff that an identification of the organisational barriers and complexity in systems became apparent. The application of leadership seen by EENs as the role of the RNs in this context was one of collaborator, mediator and the empowering force that enabled decisions from the

ground level. Decisions occurred from each staff member's level of capacity and were subtlety endorsed or guided by the ability to lead from within the role of the RN. It was this journey of learning and discovery that allowed the RNs the ability to guide, to empower, and to be engaged in clinical decision making with staff. The research supported the literature in discussions surrounding the ability to achieve success in leading teams and required firstly that leaders must be understood, empowered and have the autonomy and authority to practice (Bogue et al., 2009; Brennan et al., 2012; Trus et al., 2012). The research concurred with the literature and identified the critical role in how teams communicate, motivate and work together to provide care (Miers & Pollard, 2009; Perrin et al., 2015; Weller et al., 2014).

The approach identified in the application of leadership in practice was the desire by staff to be engaged in the decision making process. This was a process that when discussed by participants identified with a shared approach to leadership and aligned with the distributed leadership discussed in the literature (Chreim et al., 2010; Dearmon et al., 2015; Klein et al., 2006). This distributed approach, albeit often seen as a transformative perspective, provided the setting with the leadership and the drive to enhance resident wellbeing and create an environment of positive staff satisfaction. It was in these settings particularly where the visibility of the RNs was most respected.

Correspondingly, it was the EENs who were able to directly liaise with the RNs and seek assistance. In the same context the EENs provided care, made decisions and provided guidance to the UHCWs. In this domain it was the leadership or leading and then the followership or following that occurred. In itself this leading was following a cyclical process, one of leading and being led from the role of the RNs. However, it was also a role of following and leading from the role and scope of the UHCWs. The leadership style and resultant approach was what was presented and indicated how the cyclical process of leading and following occurred amongst the clinical care staff team.

Meindl (1995, p. 331) identified that 'leadership cannot and does not occur without followers'. It is this essence that has leadership as a socially constructed phenomenon (Hamstra et al., 2014; Kanter, 1981; Kean et al., 2011). This socially

constructed phenomenon was present in the individual leadership style of the RN. Clinical care staff identified that the approach from some RNs was one of an authoritarian attitude of *'this is the way the work gets done around here'*. The literature identifies that the residential aged care setting is one where authoritarian and servant based leadership paradigms are seen (Barbuto et al., 2014; Cummings et al., 2010; de Waal & Sivro, 2012; Dwyer, 2011; Garber et al., 2009; Hodgkinson et al., 2011; Hurley & Hutchinson, 2013; Jeon, Glasgow et al., 2010;). The style of leadership commonly seen in residential workplace environment relates to the characteristics of a servant or authoritarian approach particularly as high numbers of unskilled staff are present (Barbuto et al., 2014; de Waal & Sivro, 2012). Servant leadership is seen in the residential aged care setting as one that is focused on the desire to serve others (being the resident) and the focus on followers with a sense of answerability back to leaders (Barbuto et al., 2014; de Waal & Sivro, 2012; Hallinger, 2003).

The research outlined the inclusion of an authoritarian or servant based approach however the concepts that arose more definitively outlined a desire for inclusion from staff in the decision making processes. The research outlined the desire for staff to be empowered and enabled to complete work in an autonomous and yet supported manner. This more inclusive, shared approach to care provision and decision making included the concept of engagement of staff and relates more toward a distributed or transformational leadership style (Bolden, 2011; Bush, 2013; HWA, 2012; Marles et al., 2015; Stanley, 2014). The feeling of inclusivity was supported in the literature as adding to the sense of empowerment or perhaps disempowerment that an individual may experience (Bamford et al., 2013; Choi et al., 2011; Pearson et al., 2007; Pearson, Pallas, et al., 2006). The preference according to the voices of staff was in the desire to be involved, and the need to be heard.

As an RN it was a complex role. A role that entailed the application of leading a team but respecting staff input in the decision making process. It was described as a process of ongoing governance and care decisions, of balancing staff demand, resident choices and informal power alliances that formed particularly from within the UHCW cohort. Finally this leadership was about asserting authority through respect and trust of both the knowledge and the skill of leading and

following in a team. The literature is dense with discussions surrounding the ability to achieve success in leading teams and requires firstly that leaders must be understood, empowered and have the autonomy and authority to practice (Bogue et al., 2009; Brennan et al., 2012; Kanter, 1977; Trus et al., 2012).

The research concurs with the literature in that teams play a critical role in how they communicate, motivate and work together to provide care (Miers & Pollard, 2009; Perrin et al., 2015; Weller et al., 2014). A team was often represented as more of a family; a family seen as a common group of staff, working together for sometimes long lengths of time. For many clinical care staff in the residential aged care setting the longevity of working in the setting added further to the informal and formal alliances that developed. The leadership shown was about the people, the roles each person played, the teamwork, the collaboration, the communication, the liaison, and in the application of these concepts in leading and following. This was the leading that covertly occurred as decisions were made and work was completed. This management and supervisory role was identified as inherent in the requirements of the RNs. The following that occurred in enabling a team to work together was sometimes led by UHCWs and the tasks that were needed and sometimes by EENs in care provision. The visibility of the RN and the knowledge that if needed the RN was a phone call away was all that was required. This was an important aspect in the ability of the RN to be accepted and respected in the leadership role.

The art of leading and following was described as a fine and delicate balance of firstly understanding the construct of leadership, and how to enact the knowledge and principles of leading teams. Secondly, the application of these in the physical sense of working with others in leading teams and in finding the balance between the understanding and the application was key. This balance wavered at times, as seen from one RN voice that expressed the doubt and hesitation at times experienced from their role *'so it's very hard to be a supervisor and be a leader, and lead teams'*. Ultimately a team was led by the RNs in decision making and care evaluation with the outcomes a process of teamwork and a reliance or trust and respect in the people that work collectively together.

9.2.2 Staff Trust and Respect

A key concept that emerged from the narratives was the notion of trust and respect. This trust was an inherent expectation from staff in the application of the leadership role of the RN. This concept was also discussed in relation to the understanding of the leadership role of the RN with specific relation to the sub category of 'knowing the people'. It was the people in the care team who were empowered through a trust developed in the RN leader. This trust was inherently linked to the ability of the RN to gain the respect of the clinical care team.

Reciprocally, the respect anticipated in the application of leadership resulted from the concept of control and demand in the delegation of work in the team. The research unveiled the staff's perceptions and at times a level of frustration, a slowing of the work required, and the inability to control or manage the areas of care that comfortably fit within the particular staff member's scope of practice. It is the same for care in an aged care facility where the family seek the best possible care for their loved ones, and seek only positive interventions, comfort and support. It was from the responses from particularly the RNs to family questions and concerns or the complex discussions around end of life care that families sought and placed trust in the nursing profession to deliver (Hasson et al., 2008; Marcella & Kelley, 2015). This placed the role of the RNs as a fundamental link between family, resident and care provision both in the research and concurred through the literature (Marcella & Kelley, 2015). The challenges associated with staffing identified the complex web of interactions and transactions surrounding residents that were key to the day to day practice of the UHCWs, EENs and the RNs.

The role and scope of the EEN led to suppressed feelings of pressure, feelings of being undermined or forgotten in the decision making processes of working day to day in the aged care setting. Discrepancies surfaced with some EENs displaying the trust and respect in the teams they worked in. For others however, questioning and doubt appeared. The role of the RNs was a delicate balance of inclusion, of decision making and of adherence to best practice standards. The literature highlights that in some settings the EENs were viewed as being the 'registered' individual on shift with the on call capacity for a RN as deemed relevant (Milson-Hawke & Higgins, 2003). The professional approach in the leadership role of the RN was one that was

required to understand and include the EENs in the decision making process. It was the ability of the RNs to successfully navigate staffing teams that was desired from the EENs. The capacity of the RNs to be comfortable in sharing the care, understanding and valuing the team in the decision making process through the provision of guidance and know how in care provision was sought.

Trust was expressed by the RNs with the expectation that staff made contact with for advice and guidance when situations arose. The experiences outlined the decision making process, how and what engagement staff displayed and the personal feeling of inclusivity. The delineation of roles became apparent and the need to supervise and lead teams from the front was what staff wanted. The literature also discussed the difficulties with scope of practice from the role of the EENs and outlined role delineation, disillusionment and erosion that occurred in the residential aged care setting. The delineation of roles and registration practices surrounding the scope of practice and levels of professional accountability became noticeable (Jacob et al., 2013; Kenny & Duckett 2005; Milson-Hawke & Higgins, 2003). There was a feeling of discontentment not with the work itself, more surrounding the systems and the challenges from within the role of the UHCWs whose scope appeared to continue to grow. It was in the knowledge of these expressed concerns that the RNs were able to subtlety enable the leadership required to respond, and to be heard and visible to staff. Working in the setting entailed that staff knew and understood their role, that assistance was sought when needed and that staff continued to provide the best care they knew to residents.

The presence of dissention and unspoken dissatisfaction added a further complexity and layer to the work established and maintained in teams led by the RNs. Team dynamics and the work conducted together, in and amongst teams, was critical, yet in this respect overshadowed by personal feelings of disenchantment and role confusion or intrusion. Australian registration of the EENs excludes areas of assessment or client evaluation in their scope of practice (NMBA, 2016a). In the residential aged care setting the EENs were quite normally placed in the position of coordinating care within a distinct area in the facility. The EENs had a reliance on the RN, yet had the advantage of knowing their residents, seeing first hand when a medical concern arose and yet in the same context had the need to engage with the

RNs for care decisions. The leadership demonstrated by the RNs at this point was critical to the success or failure of the communication and direction provided.

Success was usually driven by the subtle approach of building and maintaining teams, of sharing decision making and of engagement of the EENs in this construct. A team spirit evolved in the settings. This team spirit was reliant on the trust and respect seen and lived from being part of the collective team. A cultivation of trust developed through the actions of staff and the application of the leadership role of the RNs in the guidance of staff in their day to day work. This application of leadership was guided by the RNs with communication, commitment, mediation and dedication to respect and trust the team they worked alongside.

The realms of clinical leadership prevailed from the formal constructs of clinical leadership as discussed in the literature by Stanley (2014). Stanley (2014) identifies key characteristics in clinical leadership inclusive of their level of approachability, support, mentorship and visibility in practice. It was these attributes that aligned with the staff in the residential aged care setting and aligned with the leadership heard, seen and enacted by the RNs. Stanley (2014) discusses specific areas of communication, behaviour and integrity. These values aligned with the research outcomes discussed in this thesis. Their alignment is an attributable factor in the congruence and capacity of the RNs to be further defined in relation to the clinical leadership role that has been discovered in greater context and clarity.

Commitment was seen in this context as an important part of trust. This involved every member of the team helping and assisting with their professional and personal expertise and understanding. The standard communication portal observed and discussed was where participants described the notion of a journal or diary reporting mechanism. It was a process of leaving notes, adding communications to a diary outlining resident appointments, changes to lifting equipment needed, family requests for meetings or outings and the list went on. It was a dependent process that entailed the leaving of a message. Communication in the setting particularly of the care needs of residents was important. This communication further enhanced the collaborative team approach and allowed staff a voice in the setting relating to the care requirements of residents. The inclusion of the voice of staff in teams was expressed in the literature as a way of engagement, of inclusion and of gaining the

trust and respect that a leader required and the resultant feelings of power and inclusion by team members (Bishop, 2013; Egan et al., 2004; Faulkner, 2008; Tuckett, Hughes, et al., 2009).

Direct communication from one staff member to the next was seen and observed within the context of the residential aged care setting. The complexities of working in a team and communicating in and throughout the team, were fraught with risk of error. It was the direct communication of care requirements from one staff member to another that informed and included staff in care and care decision making (Kiernan, 2015; Perrin et al., 2015; Scott-Cawiezell et al., 2004). Direct communication created a sense of team and team inclusion. Communication also allowed for the application of the leadership role of the RNs to have the autonomy to work collaboratively with staff in the decision making process. It was this application that articulated the notion of the art and science of caring, of balancing care requirements and of allowing the leading and following regime to develop from the leadership role of the RN.

This collaboration with others to achieve the required outcomes formed a partnership of understanding of the leadership position and of the application of leadership in practice. The art and science of nursing was seen as a key foundation in the literature where the ability to know the theoretical context of a situation and then have the ability to apply in practice the guidance, support and required interventions was key (Donohue-Porter, 2014; Ibrahim et al., 2014; Jeon, 2014; Scott-Cawiezell et al., 2004; Williams et al., 2011). This notion is akin to the art and science of nursing of understanding and leading care, of decision making and knowing collectively with the incorporation of empathy and consideration. This collective cannot be achieved by one, and requires the team to orchestrate the effort.

Autonomy was linked to the ability of team members to have a reliance or trust in one another (Brownie & Horstmanshof, 2012; Kendig & Duckett, 2001; Kendig et al., 2010; King et al., 2013). Important to the application of the leadership role was the knowing from each staff member of the negative consequences of not following through on individual resident commitments. Inclusive in this parameter is the ability to communicate changes in condition or care needs to the RNs. This success related to the trust instilled in the team and also with the respective RN.

Emerging in this concept the notion that the RNs were available and were able to perceive and know when interventions were needed. The trust and respect in the team was essential to maintain and collaborate with staff. Through the use of direct communication portals, written communications and a responsive team of staff, a consistent and meaningful communication was achieved (Kiernan, 2015; Perrin et al., 2015; Scott-Cawiezell et al., 2004). Meaningful communication was seen in the research in the trusting relationships that were formed, the subtle visibility of the RNs, the ongoing collaboration and respect given and the familiarity staff had in the teams of people they worked with. The formation of a collaborative environment was built on credible relationships, personal relations, influences and the alliances that were formed in the work teams. Each of these concepts based on the trust and respect formed, developed and enacted in the application of leadership in care teams.

The research identified that the sub category of respect was viewed as a partner to the sub category of trust. Respect was seen both in the research and the literature as having a rapport with others in the team (Asencio et al., 2012; Lanzoni & Meirelles, 2011). This rapport was a reciprocal process where learning occurred, where communication was respected and encouraged and where the delineation in the role and scope of practice was clear and concise. It was this area where conflict or questions surrounding a staff member's capability arose. The research outlined that the leadership provided was about the presence of trust and the respect given to the EENs, their inclusion in the decision making process and the follow-up to ensure that all was now resolved. The leadership was not about the giving of an instruction in a sense that a demand was provided or that the delivery of the message appeared authoritarian in approach. This distributed approach to leadership was viewed by staff as the most appropriate. The respect was an outcome of working in teams where a reliance on each other was at the fore, where communication with the RNs was overt and where resident care was transparent and cohesive.

The application of the leadership role of the RNs was visible through the trust and respect observed and enacted. As the research outlined a shift in the experience of the leadership role of the RN unfolded. The importance of trust and the ensuing respect were noted however the interpersonal relations and staff alliances became evident. The shift in experience to one of power and control in the application of the leadership exerted by the RNs was evident, detailed and outlined by participants.

9.2.3 Influencing Care and Decision Making

The leadership role of the RNs was viewed by their willingness to engage and their understanding of the influences and their effect on staff in the decision making processes. Venturato and Drew (2010) explored the use of an innovative model of care in an Australian setting with the rationale highlighting the complex, complex nature of staffing issues in the sector. The model considered education, clinical leadership and delegation and accountability in its application (Venturato & Drew, 2010). The results indicated that models in residential aged care settings needed to consider the leadership provided by the RN, with a focus on leading in practice rather than the doing in practice (Venturato & Drew, 2010). This research concurs with these principles and outlines the teamwork that emerged was from a system of knowing, and a process of doing. This system provided the scope of practice for the RNs and the context for the application of confident, self-assured and empowering leadership to be performed by staff. The research outlined many positive anecdotes however all at some stage in the conversations drew on the notion of the RN and the 'busy-ness' observed or perceived by staff. The literature demonstrates that there are areas of deficiency in relation to clinical leadership education and training for the RN particularly in the field of aged care nursing (Dwyer, 2011; Stanley, 2006; Venturato, 2007;). The research concurs with this literature and opens future areas of RN education parameters in the residential aged care sector.

Situations were also discussed that were indicative of the professional versus personal power from within positions. It was these discussions where behaviours appeared that were manifested in poor communication and conduct as a result of the pressure and stress of an individual or team. The position descriptions were where the differentiation of roles began. The understanding of who was responsible for what area of care where large numbers of residents required attention and assistance was often misleading or 'grey' in interpretation. This ambiguity resulted in a dichotomy of what each staff member was required to achieve, was responsible for, and was able to legislatively complete within a derived scope of practice.

The staff discussed the differences from RN to RN, and the instances where care decisions needed to wait, sometimes for a few hours, others for the next shift or the next day. The staff declared that it depended on the RN, their style, and their

decision making capacity. The research findings further articulated that for the RN, the leadership was a fine balance. It was a moment of decision making where the balance of the communication, the non-verbal and verbal approaches, the timing and the inclusion of the staff involved was in synchronicity with the surroundings, the resident and the provision of the required outcome in care delivery for the resident. It was through a more cohesive distributed leadership approach that a shared operational leadership appeared. It required a distributed model that respected the staff in the team, which included their input in decisions and that maintained a sense of being, and a sense of security in knowing that the RN was available to them.

Lumby (2013) and Wang et al. (2014) discussed the use of a shared responsibility framework where each person was responsible for the care and communication of the care provided to a central person in the team. The key feature was that decision making was more distributed aligning communication, tasks and decisions with all members of the team. In this instance this referred to the leader, a facilitator who communicates, discusses, and engages staff in the decision making process. This style of communication and of leading teams comes with challenges particularly keeping formal and informal power constructs balanced (Bolden, 2011; McKee et al., 2013).

Power and control were observed as understanding individuals, and understanding differences between individuals and teams in the residential aged care setting. The voices of the clinical care team outlined the need and desire for this style of leadership however complexity could be seen by the researcher with shifts and changes in power and alliances in settings. This inequity in power balance from an informal perspective, or from the formal power of the RNs that may be undermined or failing to meet clinical care staff expectations, created a sense of powerlessness. This powerlessness was a trait that in turn inhibited the leadership enacted, known and displayed. The research findings identified that there was a complex web of interactions in the leadership role of the RN. This web created the need for the RNs to have the knowledge, the passion and the understanding to act according to a situation or a staff member to produce the harmony in the team or the balance of care provision to the resident.

Clinical care staff discussed the discord in and between staff in the power balance with informal alliances and power differentials that existed. This discord resulting in care completed in settings on an organisationally culturally accepted premise rather than by best practice standards or within a practitioner's scope of practice requirements. This noted separation between staffing groups from EENs to RNs to the increasing yet unregulated practice of the UHCWs. These roles and the delineation of the roles added a complexity in defining the leadership role of the RN in residential aged care settings.

This was further extended to finding the common road to working together in the application of leadership in the day to day practices. It was here where the research found that individual staff dynamics were exerted from both formal and informal power structures in the day to day approach to care delivery. The power of position was also shared from within the role of the RNs, and yet the power of influence was often held within the role of the UHCWs and EENs. Secondary to this, the power of position was observed in the coordination role of the EENs in the work areas of hostels and dementia-specific units of care. The dynamics and dichotomy between the two, the connections and the disconnections were displayed and shared through the narratives.

The research expressed the perspectives of both UHCWs and EENs with the difficulties of working with some RNs. The discussions related to the staff review of who they were working with before the determination was made of how the work would be completed that shift. The complexity was in the fine detail of the team and where a staff member belonged. This fine detail was more about the leadership enacted by the RN or at times the understanding that the RN had of their leadership role and how this transpired in practice. The ambiguity that arose was one where the team worked with the nuances displayed from each individual RN. These nuances became visible in the application in practice of the leadership role. These situations arose for a number of reasons including the level of experience of an RN, the level of engagement in the setting and the knowledge and understanding of the RN staff in the complexities of caring for residents. It was greater than understanding the role that was required from a RN and was more about how this was enacted in the application in day to day practice.

The perspective from a number of EEN narratives was one of frustration and visibility in knowing that the RN was not engaged in the setting. In this respect, it was the lack of understanding of the leadership role the RN had carriage of that had an effect on the team and the resultant decision making processes that followed. For the RN, the critical component was about the application and the understanding of the leadership role in the real sense of leading care in the team. This subtle yet knowing statement outlined that the power exerted from the application of the leadership role of the RN influenced the team and the individuals in the team. The research expressed the need for staff to be engaged. The concept observed by staff was about the willingness of the RNs to help, to make decisions and to be empowered to feel confident in these. It was this notion that staff believed came with experience and with a greater understanding of the aged care sector and the requirements of a RN in this context.

It was the UHCWs who identified with care being greater than a list of jobs that needed to be completed. Staff described their role as an inner sense of doing what was needed for a resident at a given point in time. It was this doing that achieved care that met the regulatory components of care provision within the Aged Care Act (1997). The informal power structures were evident within the UHCW narratives with the notion of staff being *'too scared to challenge*'. The notion was suggestive of personal alliances that developed surrounding the specific leadership style of an individual rather than as a result of the structural working environment and the need for specific outcomes in care. These informal power structures were derived from the quality of alliances and the relationships the RNs established with clinical care staff in the setting. These power alliances were identified in the literature as both a positive and negative leadership force in teams (Spence-Laschinger et al., 2010; Wagner et al., 2010). It was through these alliances that informal sources of power enabled individuals to get the co-operation and collaboration of the team they worked with to achieve the work required, or where negativity and non-compliance in requests resulted.

It was from the development of negative statements relating to the formal power base of the RNs that more informal staff alliances developed in organisations, based on individual desires and work behaviours rather than best practice standards. The negative construct of the development of alliances as a result of ineffective

leadership further created distance and factions in teams. This is supported through the literature where a lack of power or alliances creates situations in a setting where staff guard their territory rather than collaborate collectively (Kanter, 1982). The construct of performance was identified in the research and was a cog in the wheel of the application of the RN leadership role, as it was the RNs who supervised the UHCWs and the EENs in the setting. This supervision role was one of assurance that the level of care required for residents was being provided. This level of care and the accountability for leadership remained within the realms and role of the RN through both registration accountability means and also organisational expectations (NMBA, 2007, 2016b).

The research also identified that the leadership role of the RN had many parts that differed depending on the prior experience of the RN. The undertones of the need for guidance, support and direction also presented alongside a layer of confusion and role ambiguity, however also a layer of control and dominance at times from the RN. A professional accountability, a set of governance and legislative obligations and yet on the ground a need to make decisions and respond to staff, residents and families with day to day operational care provision was identified. The literature shares a consonance with these concepts with particular reference to the opportunities that have arisen in the discussions surrounding clinical leadership in the residential aged care setting (Chen & Silverthorne, 2005; Stanley, 2014; Venturato & Drew, 2010). Linked with the notion of a distributed leadership approach to decision making and care delivery the concept of clinical leadership was seen as the idealistic approach to RN leadership in the setting. Working together became a key concept derived from both the understanding and in the application of the leadership role of the RNs. The complexity and forces that subtlety were observed or enacted were seen in the way leadership was both perceived and received by staff teams in the residential aged care setting.

9.2.4 Focussed on Care

The concept of knowing and doing or understanding and application was a key facet in the coordination of staff and care requirements in the residential aged care setting. It was at this stage that the acknowledgement of the resident was important. The research and the literature supported that the RNs caring for people

living in a residential aged care setting experienced a connection both personally and professionally with the resident (Bellis, 2010; Marcella & Kelley, 2015; Shield et al., 2014). For the UHCWs their inclusion in care delivery was key. It was the UHCWs who provided the fundamentals of care, who saw the resident each shift, each day and, that more often than not, noticed the nuances or subtle changes in their physical or psychological state. The literature identified with the role of the UHCWs as one where employment activities ranged from the completion of activities of daily living to cleaning and meal preparation (Barry et al., 2005; Castle & Engberg, 2008; Dill & Cagle, 2010; Pennington et al., 2003).

The role of the UHCW was also one where both the research and the literature indicated varying reporting accountabilities from direct to indirect communications with the RN (Barry et al., 2005; Castle & Engberg, 2008; Dill & Cagle, 2010; Pennington et al., 2003). Knowing where to take information and what to do with it was pivotal. It was here that the RN played a key role. Working in the residential aged care sector was complex and historically based on the foundations of team nursing from within the realms of a hierarchical military based system.

The concept of team nursing where resident care was supervised by an RN as the team leader and the actual provision of care assigned to EENs or more predominantly UHCWs was the most logical care option (Forbes-Thompson et al., 2006; Hodgkinson et al., 2011; Jeon, Glasgow, et al., 2010; Lynch et al., 2011). More generically, teamwork was seen as ‘a collaborative interaction and participation in assessing, planning, and delivering care’ (Forbes-Thompson et al., 2006, p. 937). Within residential aged care nursing this definition required clear and concise communication from within, and across, the team during each shift, and during the crossover of shifts. Each level of staff was actively engaged in different aspects of care provision, coordination and management within the team, and was thus reliant on each other and the communication with each other to achieve quality resident care (Bajnok et al., 2012; Bender et al., 2013). The narratives identified the notion of a more shared approach in the decision making process was preferred. This process was based more on teams working together, to derive a decision surrounding care or resident requirements.

It was the direction and leadership role of the RNs that created the leadership ambience, based on the interaction with the differing staff engaged. The application of leadership required a visibility from the RNs to remove the clinical care staff feelings of isolation, of practicing in large settings separated by space and locality from the RN. The isolation was seen as a barrier from the EENs in waiting for a response, a guiding hand or a decision relating to resident care. Staff were sometimes included as a team approach to the decision making whilst at other times the dynamics created a dissonance, or a team lost in transaction. This sense of dissonance, a feeling of disempowerment, where a lack of authority was seen, heard and identified from within the UHCW and EEN narratives. This leadership entity discovered and detailed from the voices of staff, was clear and audible in the need to be involved, the collective team spirit and the desire to learn more, discover more and enable positive outcomes of residential care.

This more holistic approach to care provision in itself was a complex paradigm completely reliant on individuals within the team to ensure success and communication of the relevant information relating to a change in the condition or situation of a resident (Bowers et al., 2011; Hajek, 2013). The models of care that contributed to this success included parameters for the scope and roles of all tiers of staff from UHCWs, EENs and the RN (Tyler & Parker, 2011; Weller et al., 2014; Zwarenstein et al., 2007). Working in residential aged care settings often differs in approach where the primary care provider is the UHCW and guidance and supervisory roles are held by the RN and EEN. Inclusive within the role of the RN and sometimes the EEN was the documentation, audit and quality parameters of compliance reporting required by accreditation standards and the delivery of complex areas of care. This created a model of care based on hierarchical needs rather than resident centred care and created a shift from the distributed model that staff preferred. It was this shift and changes to the leadership roles and recognised decision making parameters that was identified as creating the sense of imbalance, or a broken discord.

Leadership was seen in the literature as a process of engagement and of providing support and guidance (Germain & Cummings, 2010; Salanova et al., 2011; Schneider & Macey, 2007; Shield et al., 2014). The direction and care provided in the application of the leadership role of the RN was seen and enacted within the need

'to do' the role one knows, and yet concurrently to be the dependable entity. This dependable entity was one that provided the support, guidance and decision making within the broader team. This direction and care was a driving force for team morale, for the knowing that someone of authority and guidance was there and for the emotional stability when many aspects of care were required.

Collectively the holistic and comprehensive approach to care provided the baseline parameters for the care that residents accepted and for a team of co-workers that collectively worked together. Studies have identified clinical leadership as a process of leadership, and in practice it is in the demonstration of RN behaviours particularly in relation to their role (Baernholdt & Cottingham, 2011; Martin & Waring, 2013; Patrick et al., 2011; Stanley, 2014). This was an important feature as the inclusion of change agent, visionary and advocate for both the resident and the profession of nursing were seen as vital components in the role of the RN in the residential aged care setting (Anderson et al., 2003; Hurley & Hutchinson, 2013). This research affirms this concept and the interconnected nature of the concepts found. It identified a required level of dependence and reliance on the RNs in the ability to lead and guide teams in care provision. The dependence and reliance is seen as an important aspect in working in the team with clinical care staff.

Inclusive to the role of the UHCWs was the limitation in their educational knowledge, and yet an intrinsic desire to want to know more and to do more in the clinical sphere. The UHCW's cohort expressed the need for more education, for greater understanding and for more support from the role of the RNs. The UHCWs expressed their story of knowing the skills surrounding the foundations of basic care and having the ability to help a resident with their hygiene, mobility and nutrition needs. It was in the sphere of when things went wrong, when a resident's condition changed, when behavioural mannerisms altered, or when questions were raised from families that support, guidance and input were required from the RN. It was through education and guidance that the UHCWs were able to be influenced and were able to provide a level of care that integrated with the current needs of a resident. It was also through the confidence a RN instilled in the education process that a greater communication and authority to consult with the RNs was established. In-house education was identified as a key component of the role of the RN in establishing the baseline of care requirements when working with UHCWs. This education was seen

to enable teams to complete the cares required to the practice standard expected (Baines et al., 2014; Duffield et al., 2014; Germain & Cummings, 2010; King et al., 2013; Pearson et al., 2007).

The evolution of the ‘what is’ of the leadership role was further outlined in relation to the scope of practice relating to what it was that an UHCW was able to do. Once the scope of practice was determined it was then about how the communication portal worked in the team between the UHCWs, EENs and the RNs. The diversity and complexity of the residential aged care setting had the RN in charge of the setting in a global context shift by shift. This was a setting often defined in relative terms by the sheer number of residents in their charge. For some facilities this totalled 50 residents for others 150 residents. The space and capacity to engage with staff, have availability to staff and residents sometimes proved self-limiting in the application of RN leadership in practice.

The inherent need to be able to work collaboratively in the development of staff became important. Staff education was an area of discussion in the literature. The literature asserts that it is organisations with work environments and staff that can access education, training and support that have the potential to thrive (Baines et al., 2014; Duffield et al., 2014; Germain & Cummings, 2010; King et al., 2013; Pearson et al., 2007). The dissonance was noted both in the research and in the literature surrounding the traditional hierarchical medical model that dominates the residential aged care sector (Bishop, 2013; Hartley & Benington, 2010). It is this model that ensures that staff with the highest education, salary, and formal position often remain the furthest from direct contact with residents leaving the RN in a position of great accountability and responsibility however without the respect and acknowledgement of the role in a formal context (Bishop, 2013; Hartley & Benington, 2010). This further extends from an educational perspective to one of human relations. Human relations included the ability of the RNs to be able to discuss diplomatic concerns, seek reasonable workplace resolve and communicate these strategies with management and with staff. This was further revealed in the ability to develop and maintain healthy work relations with peers and work colleagues.

In these experiences the message was clear and worthy of greater appraisal, this being the one of team work. Establishing a greater understanding of the RN leadership role and how this works in teams required a discussion about the teams that were drawn together and how the team functions in the working environment from a practical sense. The teams of staff in the residential aged care setting were derived through a system of rosters, of allocation of shifts and not through the desire or selective nature of developing a team that works well together. The research identified two staffing cohorts in the residential sector. The first were those having worked in the setting for lengthy periods of time and the second appeared transient in their employment with either contractual or short term work. The nuances and differences in position, in responsibility and in the delegation and provision of care noted, added a complexity and tiered approach to care delivery, coordination and outcomes.

It was in the discovery of the compromise of working together that greater understanding was found in the application of RN leadership. It is in this sub category that teamwork evolved and formed a component in the leadership role in all staff, particularly the RN role that guided and led care. The complexities from both an organisational, individual and legal perspective arose in the RN narratives surrounding the difference between being in charge and in leading a team. The literature further clarifies this concept with discussions surrounding the responsibility and accountability for the clinical practice provided to residents in the residential aged care setting (Manojlovich et al., 2008; Swearingen, 2004; Wong & Cummings, 2007).

The presence of the RN was not always seen as a visible entity however a presence was the preferred and desired ideal by all levels of clinical care staff. It was their direction, guidance and support that assisted the clinical care staff to fulfil the cares required for a resident that participants described**.** Collectively, it was the team connection between the people employed that provided the care and that communicated the concerns that influenced the outcomes for each resident. The literature explored the role of the RN where perceptions of negativity emerged and one where responsibility and accountability arose (Tuckett, Parker, et al., 2009; Tuckett et al., 2011). This negativity drawn from the enormity of the role and the notion of 'busy-ness' in the work conducted.

This notion of ‘busy-ness’, of so much to do, was one that reverberated in the research through each of the staff roles in the residential aged care setting. It was the application of the leadership role of the RNs in practice that enabled care to be guided to what really mattered, the areas that made a difference. It was this prioritisation of care through communication, liaison and sometimes the direction provided to staff that worked. It was this aspect of direction and care that was seen as a concept in the application of leadership in practice. To achieve this there appeared to be a need for the RN to be open, responsive and educated in all areas of nursing care of the older person.

The staff who comprised the team were important individually and collectively in care provision. It was these people who individually completed the work as detailed in position descriptions, through competency standards, through codes of practice and through a genuine desire to care. The autonomy and independence to provide care was one concept that the UHCWs and EENs respected from the role of the RN. Research examining leadership in the aged care sector so often focuses on RN productivity and what particular factors affect a nurse’s ability to perform well (Germain & Cummings, 2010; Loke, 2001; Wong & Cummings, 2007). These studies have identified that RN leadership has a direct influence on autonomy, relationship building and nursing practice and the areas that influence a staff member’s motivation to perform (Cummings et al., 2010; Loke, 2001; Wong & Cummings, 2007). It was not a given, rather an area of practice dependent on the individual RN on duty. This individuality a significant component in the application of the leadership role of the RN as identified in this research.

The scope and practice of both the EENs and the UHCWs precluded their intervention particularly in areas of care relating to care assessments and evaluations. It was these assessments where the role of the RN from a legislative perspective was apparent. The initial steps in this process, the care planning, and suitable care coordination provision and documentation were the responsibility of the RN. It was the influence created through the application of leadership from the RNs in the assessment, planning and implementation of care and care requirements that became critical. This research identified the inclusion of staff as a team, a team collectively united through the provision of care and in the communication that transpired. It was the application of this care and the direction that inspired staff in care provision that

was at the fore of the leadership role of the RNs. It was care provision that respected the resident, that included the families and that responded to changes in conditions quickly and professionally.

It was through the application of their leadership that a role model emerged and expectations and standards were set and communicated with the team. The notion of intuitive knowing developed as a fine balance of knowing what was required in a particular situation and secondly of being able to mediate the delicacy of dynamics that may or may not be present to resolve the circumstance. It was in this realm that care delivery was more than just knowing, and was also represented through a skills base linked inherently with the incorporation of an emotional and spiritual side of care (Barbosa et al., 2015; Bellis, 2010; Crilly et al., 2012; Brownie & Horstmanshof, 2012; Williams, McDowell, et al., 2011).

To achieve this application, understanding was first needed. Key within the role of the clinical care staff was the ability to be responsive, to be caring and to care. An expanding area in the residential aged care setting was the need to understand and enact care at a time when end of life decisions were being made, and when care was directed toward a more palliative pathway. The definition of palliative care, in its simplistic form was the area surrounding end of life and the necessary care for residents at this time (Abbey et al., 2006). Discussions further surrounded the importance of palliative care in the residential aged care setting. This is further reiterated through statistics that identify the growth in palliative care requirements in the residential aged care setting in Australia (Abbey et al., 2006; Barbosa et al., 2015; Wong et al., 2013). For families, the palliative care provided entailed a time of sadness, of grief and sometimes of anger and questioning. For the resident, the staff identified that more often than not, residents sought comfort, the desire to stay in their room and the desire to be provided with the cares, the time, and the ear of someone to talk to, and the hand and a face they knew, to be with them.

The UHCWs explained the differences in individuals, with no clear recipe for their care, but the need for time and to provide care that met the requests of the resident or their family. For the UHCWs this created situations of uncertainty in what to do next to maintain the resident's comfort, and care. The RNs articulated the fear they saw, they sensed, and they experienced in working in the residential aged

care setting alongside the UHCWs. The palliative care journey of a resident created the relationship with staff, with residents, and with families at a vulnerable time for a resident. It was in these moments that the RN was greater than a care provider or decision maker alone. The role was one of a leader of staff, care provider and a guide and support to families. It was this sense that created an influence, difficult to describe objectively that exerted a power, a sense of endorsement of the situation, the context, and the resulting outcome. For staff it provided the reassurance that was not previously there and it allowed for a level of autonomy in staff roles, with the knowledge that the RN was present, was supportive and would be there if and when required.

The application of the leadership role of the RN was viewed as one that could provide the answers to the clinical questions, help guide the care that was needed and provide the time to share the reasons for why events, clinical situations and medical ailments or a decline in a resident's condition occurred. The RN as leader was confronted with challenges. These challenges came from a clinical, physical, fiscal and human resource perspective (Bellis, 2010; Castle & Decker, 2011; Tuckett, Parker et al., 2009). It was all of these concepts plus the experience and level of confidence that influenced the care provided and the leadership enacted. The RN provided a level of restriction seen through the implementation of governing standards, through the fear of audit and complaint management and in the ongoing demand of fiscal limitations that faced the sector and the decisions made by the RN each shift (Bellis, 2010; Castle & Decker, 2011; Tuckett, Parker, et al., 2009).

9.2.5 Navigates Regulation and Legislative Control

The focus on aged care nursing is explicit in discussions surrounding the increasing demand of aged care services nationally and internationally as the age of populations continue to increase globally (Grealish et al., 2010; Westphal, 2012; WHO, 2015). The political influence matched with a rising health care dollar spend has resulted in reductions in RN employment opportunities in aged care in Australia at a time where recruiting into the area is difficult. This research affirms that the leadership role the RN displays and enacts is critical in the residential aged care setting. The research findings articulate that in the recruitment and selection process it is about the right person for the position. The reality however often leads to RN

employment in these settings being based on the availability of RN staff and their willingness rather than the career progression or future career plans of the RN applicants.

Change as we know it is present in all aspects of life. The residential aged care setting is no different. The anecdotes of the aged care staff have identified that the leadership practice of the RN was shaped by the constant changes in the health and aged care system and in many respects through the cultural and historical context of the setting. The narratives of the clinical care staff identified a hierarchy of regulation and restriction for RNs that created the dichotomy of wanting to care, wanting to be present, yet needing to complete documentation and oversee the more pressing issues as they arose each shift. The focus of the leadership role shared by participants was one of leading and also of role modelling, and of following. The ability of the RNs to guide or mentor staff was important.

The ability to provide the communications required to ensure that staff were at ease with the surroundings of their workplace linked with the communication that occurred between staff. The need to have a professional demure that resulted in staff behaviour that matched organisational values was also required by clinical care staff. For some staff, this posed a challenge as regulation and reform continued to influence the care being provided and the scope of practice of clinical care staff was often challenged by the restrictions prevailing in the setting due to fiscal, compliance or organisational obligation. The RN leadership role was defined as positive when proactively led, when staff were able to care and seek assistance as needed or desired. The role was also seen in a less effective leadership context from within a wider system of regulation and reform where reactivity to change, to clinical situations and to fiscal resourcing demanded an additional stress and burden to the system and to the people working in the system.

It was the RN that identified their role as lead coordinator. This was further exemplified throughout the introductions provided by the UHCWs and the EENs. Collectively the participants spoke of the overt and yet often subtleties that created the picture of the 'what is' of the leadership role of the RN. What has been gathered from the research has described a complex team process to leadership where communication, the people and the influence in and between all these parameters are

crucial interlinking components. What has also been established was that change and regulation through governance structures and regulatory provisions added a further challenge in the definition of the leadership role of the RN in aged care. The challenges within the residential aged care settings are not purely governed by a set of standards, a centralised governing body or a regulation authority overseeing the professional capacity of workers. Rather a centralised legislative boundary surrounds the complex and complex area of residential aged care nursing**.** The landscape of aged care nursing is inclusive of the external changes that have derived over time and from those from within the organisational settings. These changes were evident both in the sector and in the care required by people as they aged and entered the residential aged care setting. The literature asserts this from the historical underpinnings of the evolution and continuous reform and growth that is demonstrated in caring for the Australian population and their demands as they age (Hughes, 2011; King et al., 2013).

Research following the 1997 and 2012 Australian government aged care reforms indicated that despite these challenges nursing leadership is becoming increasingly desired (Dignam et al., 2012; Tuckett, Parker, et al., 2009). The literature further asserts that it is through nursing leadership that improvements in care outcomes at both a strategic, individual and social level, can occur (Dignam et al., 2012; Duffield, 2005; Hurley & Hutchinson, 2013; Pearson, Schultz et al., 2006). Nursing leadership alone does not create the presence or the outcome of quality or satisfaction. This sentiment was expressed by the RNs wanting to work in the sector, wanting respect and acknowledgement for this work however seeking the ability to further progress their education and knowledge in caring for the aged. This research identified and confirmed with the literature on the particular education requirements within the sectors of palliative care and dementia care management.

The combinations of workforce changes with aged care reform and with the arising need for both socialisation and activities in a supervised setting, have added to the complexity of the setting. Corresponding to this is the need for the provision of resident care with rising chronicity and disease states (Moloney et al., 2016; Pearson et al., 2007; Williams et al., 2011). These challenges have resulted in the need for greater teamwork and RN led leadership in the residential aged care setting. This research has outlined the web of actions and interactions required from the role

of the RNs in the operational clinical leadership required to be effective both in teams and for the residents and their requirements.

It is a setting where clinical leadership is provided by the RNs and where audit and compliance set baseline standards of care. This care is primarily delivered through guidance and mentorship from a RN to UHCWs. For many UHCWs their position description was not standardised. The prescription of the role provided the fundamentals of care, in some facilities through education and training, whilst in other settings no training was needed and *'a learn as you go'* approach prevailed. The roles of the UHCWs are not governed by National registration standards that pertain to the profession of RN or EEN roles (NMBA, 2016a, 2016b). The requirements in the application of the leadership role ensured that the care provided was the care required. This application in practice was achieved through the ongoing supervision, education, leading, communication and influence of the RNs in the setting.

The research participants identified the changes in resident status from one of requiring some assistance to one of full care needs. The synopsis also articulated the reforms present in contemporary practice with a greater emphasis on community health provision to those as they aged. A process of ongoing reform has presented Australia with changes occurring within governance structures at regular intervals. This is further supported in the literature and identifies with the complexities that have been shared by each of the clinical care staff cohorts interviewed (Angus & Nay, 2003; Hughes, 2011; Segal & Bolton, 2009). This concept was familiar with the staff and spoken in the narratives as staff expressed the admission of residents with high care needs, and for palliative care requirements.

The aged care legislation articulates key fundamentals to care provision and staffing models alongside corresponding audit and compliance trails that exist with quality improvement and aged care funding parameters (Angus & Nay, 2003; DoHA, 2006; Hugo et al., 2009). The responsiveness of the decision making process and the support and information provided by the RNs to clinical care staff was key in the link between organisational requirements and care provision. The communication that supported the decisions made was a component of care that sometimes became a web of notes, oral and written communication or a hearsay from one shift to the next.

According to the participants it was the RNs who exhibited this application of leadership in practice and provided the mentorship, the guidance and the autonomy to allow practice and decision making to occur.

Lindsay, Day and Halpin (2011) further elaborated on clinical leadership with an enhancement relating to the shared governance strategy. This strategy according to Lindsay et al., (2011) is key in building a team's capacity for leadership that goes beyond the title a leader holds. It was this construct that distinguished between the leadership of a team and the leadership in a team. This leadership was identified from the voices of staff in the residential aged care setting where the EENs and the UHCWs assumed roles in leading areas of care, in team coordination in specific units of care and in the provision of care requirements from the fundamentals of care to medication administration. It was this shared approach discussed in the literature (Chreim et al., 2010; Dearmon et al., 2015; Lindsay et al., 2011) that surfaced in this research and which placed responsibility on team members. Further, it was this responsibility where the leadership emerged from chords or patterns of interactions from team members. This responsibility and resulting RN accountability trail depended on the respect and rapport of the RNs with the broader team in the setting.

The participants all informed, all did their best and all highlighted the importance of scope of practice. It was however an enlightening experience that portrayed the reality of the setting, the challenge of competing demands and the time that often led some to make decisions that otherwise would not have occurred. The complexity and the corresponding obligations of staff in a setting that appeared stretched both fiscally and in human resources became evident. The complexity further noted the need to care, the want to do the right thing and yet the inability to provide care in a timely and efficient manner. Working as EENs or UHCWs was described as a position of being able to provide in some areas, yet waiting for the RN for assessment and care planning guidance in others. For the RN, the leadership they described was sometimes a product of the competing demands of the organisation. It was the reality of the balance between the distributions of time to each of the areas within the setting.

This research identified that care provision was supplied to meet compliance rather than the holistic approach to care and to the social care coordination requested

from a resident. The provision of an autocratic leadership style governed by the need to complete the 'job lists' was in stark contrast to the coordinated team approach staff sought. It was this synopsis that clearly outlined the differences amongst facilities all working generically toward a common goal of quality resident care. The understanding and application exposed the presence of a hierarchy of control that in application was seen in aged care reforms and practical restrictions to practice. It was this that produced an intricately interwoven scope in the RN leadership role. This boundary provided a constant appearance in the leadership landscape enacted by the RN and related to an expression pertaining to the challenges of working in a system highly regulated however fiscally resourced. In part, this constant presence was seen in the competency standards of the RN where accountability was seen in the planning, evaluation and care coordination role (NMBA, 2016b).

The leadership from and within the RN role provided the integral link between the resident, care coordination and the organisation. It was the RN who effectively led the team and the care to ensure compliance with regulatory standards in the setting, and quality resident outcomes as people aged (Anderson et al., 2003; Bishop, 2013; Venturato & Drew, 2010). The literature asserted this premise and the research identified this in both action and understanding through the role seen, heard and felt in the presence of the RNs and their leadership in the residential aged care setting.

In reality the residential aged care setting provides care for large volumes of individuals with minimalistic staffing capacity (Tuckett et al., 2007; Tuckett, Hughes et al., 2009; Venturato & Drew, 2009; Venturato et al., 2007). The result of this transition is a reactive system of solving problems as they occurred rather than a proactive approach to chronic disease management and palliative care. The literature concurs with this finding with a number of authors outlining that care is often based on priority, and reactivity to situations and resident events and not always on the planned prioritisation and leadership of the RN (Bellis, 2010; Castle & Decker, 2011; Tuckett, Hughes, et al., 2009). This is said with no disrespect to the individual staff providing the care as their intent appeared always with the resident as key priority. The voices of the clinical care staff have been heard and echo the sentiments of a group staff seeking to care, seeking to provide best practice to the aged however

working in a system of limited capacity and capability from a staffing and fiscal resource perspective.

The reform and restriction viewed by clinical care staff that worked together often in compromising situations, was a trait that was explicit to the leadership role of the RN. The noticeable reform and restriction created challenges in meeting the balance with staff to meet resident needs, and the need for an ongoing trail of quality audits and compliance monitoring to provide the required evidence of performance to standards. The ability to engage, work shift work, coordinate care and be responsive and engaged with large volumes of residents in a facility created great challenge. Further to this notion, the capacity of the RNs to ensure that staff were informed, educated and practicing within required guidelines and care practice was key in the success of the leadership role of the RN. The research noted the importance of the leadership role of the RN and its influence on decision making, on team building and on resident reassurance when a problem arose. It was this presence, the unspoken, and the innate responsibility and mentorship that were identified in the role of the RN. It was an interesting concept, and one that differed from RN to RN, in the sharing of both a personal and a professional component. Key within the context was the underlying sub category of communication and of the need to manage resident issues in alignment with both resident health care needs and within the aging in place model where audit and compliance standards were high. The discussions led to the open and transparent need in the current climate and residential aged care setting to provide care to the resident as increasing health issues prevailed. The notion of aging in place and caring for an individual at a time where end of life care dominated, for some staff created challenges in care provisions, challenges in understanding the complexities of the situation and personal challenges having cared for and known the individuals often for long periods of time.

The leadership role of the RNs as reviewed in the literature was collectively about working in and within teams, leading, making decisions and managing the communication from resident to carer, to families, both in and throughout the organisation (Anderson et al., 2003; Anderson & Reuben, 1998; Donohue-Porter, 2014). This linking role for the older person involved the coordination and management of chronic illness assessment, care and evaluation, and the communication of care decisions, changes and updates with both resident, and if

requested, the family (Bellis, 2010; Crilly et al., 2012). The categories of understanding and of application articulate the essence of the literature in practice through the voices of the clinical care staff from within residential aged care settings. These concepts have been further discussed in their essence as the leadership role of the RN is seen as one of responsibility and accountability achieved through a level of interconnected dependence and reliability.

9.3 CHAPTER SUMMARY

The presence of understanding the construct of leadership and then in practice the application of the practical conceptions of this RN led leadership otherwise known as the knowing and the doing approach, have been presented. It was in this role that RNs saw the ability to lead, the aptitude to follow and the ability to influence the care provided to individuals in a positive and respectful manner. It was this influence that revealed that the RN instilled a passion in staff and a trust and respect in the decisions that were made. In understanding the teams that the RN led an understanding was able to be gained in the way teams worked and in the trust that resulted from staff feelings of power and respect. It was in this concept that the power differentials were aligned and teams became constructive in care provision and a level of trust and respect followed. The literature supports this concept with collegiality seen as an outcome of this team approach and was seen as an area where staff engagement and feelings of respect were enhanced (Bishop, 2013; Egan et al., 2004, Faulkner, 2008; Swearingen, 2004; Tuckett, Hughes et al., 2009)

The application of the leadership position has been discussed in this chapter. The application of leadership was not derived from one single person, nor does one style of leadership prevail. The application relates to a number of sub categories related to caring in practice. The UHCWs and the EENs required the leadership role of the RN to influence and collaborate with staff on care decision making.

Chapter 10: Conclusions

10.1 INTRODUCTION

Chapter 10 considers the collective experiences that emerged from the research by bringing together the condensed meaning in a definition of the leadership role of the RN. Section 10.2 discusses the context that has been identified in the leadership role of the RN in the residential aged care setting. Section 10.3 defines the leadership role of the RN with a summary of the conclusions and considerations for practice outlined in (section 10.4). The chapter concludes with the implications for the RN (section 10.5) and for the residential aged care setting (section 10.6). The strengths and limitations of the research (section 10.7) are outlined and the recommendations for future research identified (section 10.8).

10.2 ESTABLISHING THE CONTEXT FOR AGED CARE RN LEADERSHIP

To understand is to know. To know is to be able to act. To act is to have the ability to perform and to produce. The understanding of the leadership position and the application of leadership in practice have been discussed in chapters 8 and 9. The meanings generated provided greater depth and discovery and in a sense the definition of the leadership role of the RN as a collective whole. What developed throughout the research was a summation of the leadership required by the clinical care staff working with the RN in the residential aged care setting.

The understanding and the application of the leadership role of the RNs required staff who had the capacity to know, the capacity to learn, the capacity to understand and to motivate and engage a team in care delivery. Leadership was not alone in the title or role an individual held but rather in a presence, a being, and an understanding and enactment of the required interventions that followed. This research has provided a cornerstone in understanding the complex and dynamic role the RN encompasses in the day to day leadership provided in the residential aged care setting.

10.3 RN LEADERSHIP DEFINED

The conversations held with the participants identified a number of concepts, some from the day to day operational work, and others from tradition and culture. These concepts included the people, the environment, the care, the influences, the standards, and the multiple layers of policy drivers that existed. The research was about learning more about the leadership role of the RN, finding something new, and reaffirming what was known but not really understood in the contextual space of the residential aged care setting. The RN leadership was identified as a complex entity. The fine balance between the understanding of the role of the RN and the application in practice was seen as the key components in the definition of the leadership role.

The interpretative phase of analysis allowed for the emergence of a clinical leadership. This clinical leadership seen in Figure 7 is depicted as the combination of both the understanding and the application categories. The definition was identified as a multipronged entity with sub categories and concepts arising in both the understanding and the application of the leadership role of the RN.

Figure 7: The RN clinical leadership architecture

The RN was required to have understanding of the leadership role. This understanding was about the ability to know the components, the linkages that occurred and the ability to problem solve, negotiate and navigate through the challenges of each shift. The research conducted and the literature confirmed the restrictions of time and capacity presenting barriers for the RN given the volume of residents in their charge each shift (Castle & Decker, 2011; Tuckett, Parker, et al., 2009; Tuckett et al., 2011).

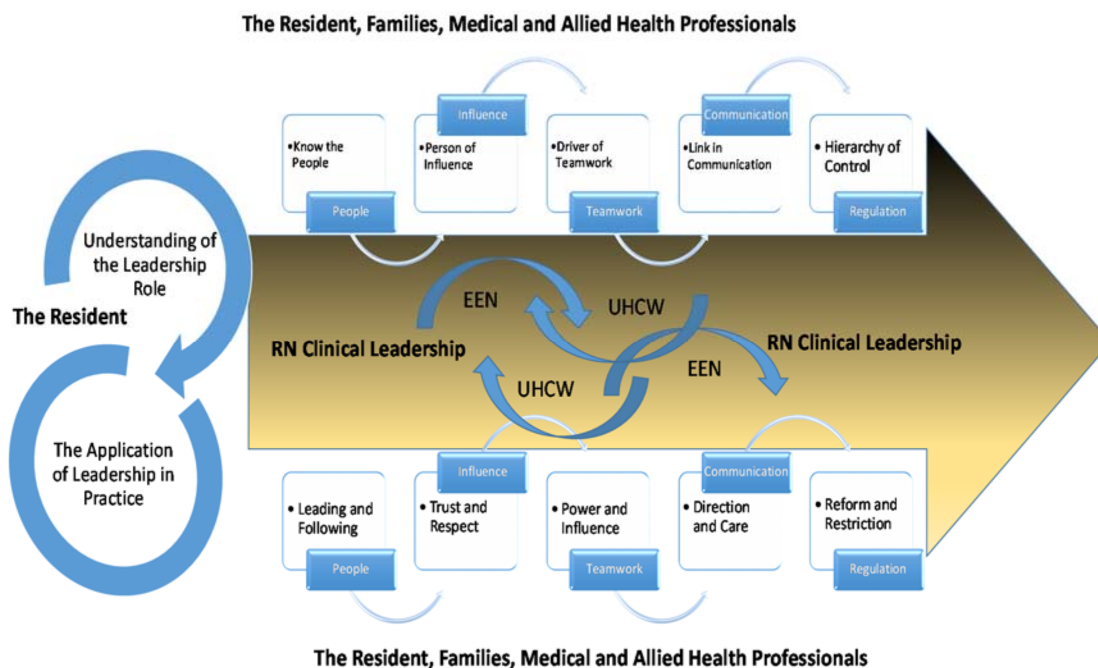
The RN was required to apply the concepts identified in the understanding of the leadership role in day to day practice. The resultant application of the leadership role provided the staff with the desired clinical leadership, the visibility and presence of the RN in the setting and the ability to perform, guide and mentor staff at times of need. The literature captured the role of this clinical leader as the effective manager of a team in the provision of clinical care (Howieson & Thiagarajah, 2011; Stanley, 2014; Venturato, 2007).

The interviews have engaged and enabled the extraction of anecdotes and stories in a quest to capture the essence, understand the reality, and share the experience from the team working closely aligned and in collaboration with the RNs. The understanding has been captured as a complex domain in its own accord with five sub categories emerging. The sub categories of the people, the influence, the team and the communication are key areas within the domain of understanding. Each of these sub categories is independent in their presentation in the leadership role however also intricately interwoven through both the understanding required from the RN and the application of these areas in practice. Explicitly the interconnectedness of these categories and associated sub categories provided the scope and depth of knowing more of the 'what is' of the leadership role of the RN. The categories shared an interconnectedness of caring, of shared responsibility and yet of authority and dependence.

The application of leadership highlighted the need for staff to work collaboratively to achieve all health and social care requirements of individual residents. The analysed narratives revealed the diversity in care, the need for assessment of residents, the need to cover a broad range and depth of issues whilst at the same time providing support and education to clinical care staff. This research demonstrated that the application of the leadership role of the RN played a key role in the coordination and in the organisation of staff, and in the communication of care plans to the resident and to their family. This research demonstrated the dependence and reliability of the role of the RNs to link the organisation, its management and governance processes to the staff and the resident. The alignment between both the organisation and the clinical care staff was in the communication role of the RN. This communication in and between staff, organisation, resident, family and external health providers, became a catalyst for care provision and a catalyst for staff

understanding and compliance with organisational and government requirements. For the RN, it was about their conduct, their leading, their following, the rhythm provided and the environmental culture created. The leadership seen was greater than a RN and greater than just an ‘understanding’ and ‘application’ of leadership in its pure sense of definition. Rather the leadership that emerged was a collective balance of the ‘understanding’ and the ‘application’ and their respective sub categories integrated more broadly from the role of the RN working together as a member of the clinical care team. This representation is seen in Figure 8 where the essential requirements identified in ‘understanding’ must prevail for leadership ‘application’ to be effective in translation.

Figure 8: The interconnected model of RN clinical leadership in residential aged care



The concept shared was the need for an RN who was able to understand and act, was able and willing to apply, be present and educate on the health care needs of staff and residents as they arose. The emerging concepts identified with a RN that was responsible and accountable and had a sense of knowing and with this knowing a dependence and reliability. It was these notes that linked the concepts and constructs of the research findings to describe a clinical leadership seen and enacted from the RN and clinical care staff in the residential aged care setting.

Each of the areas in the definition highlighted the leadership seen, heard and enacted by the RN. The definition entailed a large scope in the role and practice of a RN in the residential aged care setting. This role and scope was further outlined in the conclusions drawn from the research. The role of the RN has been outlined both in the literature and in this research as a complex, multi-dimensional role. The complexities relate to the multiple concepts all required to collectively combine, align and act as a whole.

The characteristics that presented support the complexity in the leadership role discussed in the literature surrounding clinical leadership. The characteristics of the leadership defined in this research consistent with the philosophies of Stanley (2014). These characteristics align with approachability, competence, mentorship, visibility, integrity and having communication, competence and guidance in care decisions at the fore (Stanley, 2014). Similarly the characteristics align with the work of Mannix et al. (2013) in an integrative review of clinical leadership that identified the realms of clinical leadership and require a follower, leader, a team approach to care coordination, the establishment of therapeutic relations, the ability to influence, and to be a motivator. These combined concepts form part of the essential chords in the construction of the broader, lesser detailed definition of RN leadership in the residential aged care setting.

It is in the more condensed meaning found in the research that the definition of the leadership role was found. This was identified in the clinical leadership inherently found in the role of the RN in the residential aged care setting. This research has ascertained that the definition of the leadership role of the RN in residential aged care settings is to:

1. Know and understand the clinical sphere, and its capacity and influence on the clinical care team.

2. Act according to clinical need, team cohesion and organisational priority.

3. Apply, perform and produce in the domains of both understanding and application to the needs and priorities of residents, staff, management, medical and allied health professionals, families and facility liaisons and visitors.

4. To provide resident and team outcomes within prescribed environmental and legislative guidelines.

To enact this leadership is hard work. Imbalances in one aspect create tensions in another, with the balance disrupted when misalignment occurred. Further to this the pace of the setting, the anomalies in care that arose, the audits and quality inspections that prevailed and the ongoing consumer demand for greater services and for attention to areas of need in the settings created changes and alterations to the tempo. On the surface the leadership role of the RN appeared as a role that was needed when *'things went wrong' or 'when a clinical decision was needed'* however in reality the leadership role of the RN was the catalyst that created the space, the ability and the know how to plan and coordinate the services being provided in the operational day to day care requirements of those living and residing in a residential aged care setting.

10.4 CONSIDERATIONS FOR PRACTICE

There is much to learn in the space of the leadership role of the RN in aged care. The categories that emerged in this research complemented by the literature and political drivers, identified the need to have the 'care of the older person' recognised as a specialty area of nursing. This recognition and the education and mentorship drivers will assist the RN role in the aged care context. Secondly, the benefits of this recognition and education with specific interest in caring for those as they age, potentially adds benefits to the recruitment and retention of staff in the setting.

Application in practice requires the transference of the sub categories of understanding into residential aged care nursing. The education of RN leaders requires consideration to include the development of a multi-pronged approach to the required education in caring for the older person. **It is recommended that mentorship and leadership programs for RNs in the residential aged care settings incorporate the focus on both the understanding and application of nursing in practice and in working with teams of EENs and UHCWs from a clinical leadership perspective.**

The leadership in practice requires an industry specific induction to establish career planning. This induction requires the inclusion of practice leadership that offers a preparation to employees in residential aged care settings to the nuances of the setting, coordination of UHCWs, the isolation and independent decision making pathways and to the specialisation pathways of gerontology, dementia or palliative care studies.

There is a need to consider the drive to have the wage disparity that exists in this sector rectified, acknowledged and consistent with recognised specialty areas of nursing in Australia. Although this premise is outside the realms of the research conducted, it remains consistent with the need to recognise, acknowledge and offer career progression and education in this space, a core concept in the leadership role of the RN. **It is recommended that the definition of the leadership role be included in political discussion to voice the complexity and demand in the role. It is recommended in this discussion that the wage disparity become a greater agenda item in the political sphere with emphasis on the leadership role defined.**

The context of the operational caring that occurs within the leadership role of the RN in residential aged care settings has been determined in its complexities in this research. The position descriptions as they stand engage and collectively outline the roles of both RN and EEN accountabilities with differentiation relating to the lines of reporting responsibility and overarching accountability. The specialisation of caring for individuals as they age is represented in both the literature and in the research conducted as a complex, multidimensional area of care. **It is recommended that a redefinition of the role the RN in aged care be explored and considered in residential aged care settings.** This redefinition aims to ensure that the parameters of complexity are captured, articulated and supported in practice with particular reference to the required leadership, governance and guidance required to staff and the teams in residential aged care.

Discussions surrounding scope of practice became apparent in the research. Staff spoke of blurred lines in their prescribed scope of practice and EENs spoke of a shared position description and responsibility of scope to that of a RN. Nuances were noted and all participants resoundingly identified the RN as the responsible entity, the one figure accountable for practice in the residential aged care setting.

The scope of practice requirements of the RN requires further delineation. It is recommended that this delineation occurs in line with the redefinition of the role specific to the residential aged care domain and the nuances and RN requirements within this scope of practice area.

The concepts that have arisen in the findings of the research have outlined the understanding and application of RN leadership. The concept of leadership governance appears to be a critical point in an organisation. The RN on the whole was able to effectively display the leadership to provide vigour and motivation to a team. The key areas of support, guidance and direction were outlined as essential drivers to ensure that this leadership was visible and available to clinical care staff. This leadership was seen in the communication, education and engagement of clinical care staff. The suggestions, feedback and intervention or requests for resident reviews brought together the team, the skills and balanced the communication, power and the influences in the setting to effectively formulate the leadership role of the RN.

The research has outlined the need for the leadership role of the RN to be the responsible and accountable entity that was available to staff surrounding the decision making processes in the residential aged care setting. **A recommendation is made for the inclusion of a national priority for the development of professional standards of practice in the subspecialty of residential aged care nursing.** The professional standards should be inclusive of the:

- clinical care coordination requirements,
- professional stance of gerontology care in both understanding and the application of care in practice,
- legal and ethical components of care,
- coordination of UHCWs in care provision,
- clinical leadership principles inclusive of the understanding and the application enacted in aged care; and
- decision making capacity of the RN in aged care.

The identification of a clear and transparent professional standard is an area that requires greater discussion and a more refined categorisation and eventually an

education and career pathway for aged care staff. The role of the RN has been outlined by the clinical care staff in residential aged care settings. The differences in scope of practice and in the leadership role of the RN have been outlined. The findings of this research combined with the literature on recruitment and retention research and the literature on the regulatory domains that exist identify a need for professional standards in the area of gerontology nursing or the gerontology specialist RN. This concept is further heightened with the known increase in service requirements in the decades to come in caring for residents as they age and the need for the RN to be able to effectively manage, lead and coordinate teams of UHCWs. Coupled with this is the need for the RN to know and understand the complexities of care required and the maintenance of the social care parameters of individuals in the setting and indeed this sub speciality area in nursing.

This role delineation is further aligned with the need for clear and concise communication channels within the sector and from within the role of the RN. To enable the required effective communication identified in the findings of the research there was a clear need for greater independence and autonomy from within the role of the RN. The communication and action of the RN in the daily operational requirements in the setting was an area that absorbed the RN in ongoing communication, decision and practice accountability. It was in these areas that a definitive line in the role and autonomy of RN leadership seen and enacted by the RN requires greater definition. **The recommendation is that the communication channels and pathways be explored further to enable the leadership role of the RN to gain autonomy in lines of communication, authority and action in practice.**

The education requirements of the RN were identified in the research as being a key component of their leadership role. The RN was required to educate others in the team, problem solve and liaise with families on clinical, personal and behavioural related concerns. The literature identified low numbers of staff in the residential aged care setting undertaking post graduate training. The literature also affirmed that the leadership role of the RN was not viewed as a subspecialty area and career planning in the space was limited. The research identified the specialist role the RN enacts in both providing and having the understanding of the complexities of conditions that prevail in residents and the resulting governance boundaries and

reporting mechanisms that present. The research articulated the need of the RN to apply these principles in practice. The clinical care staff voices collectively acknowledged the need for RNs who were responsible and accountable and that had a dependence for caring and a reliability that staff were able to access and seek assistance as required. The prior recommendation for consideration and further work into the defining of professional standards for the residential aged care RN or gerontology specialist nurse further enhanced the debate and recommendation that residential aged care nurses continue to lobby for it to be recognised as the subspecialty area it deserves.

Through education, research and the use of evidence to guide practice, staff can become more enabled in their roles to assert greater leadership capacity in their scope of practice. Increasing leadership capacity and confidence provided a key role in assisting in staff recruitment and retention models in the sector (Hayes et al., 2012). This research offers RNs with education relating to learning more about themselves, their ability to work with others and in leading and shaping the aged care workforce. Coupled with the findings of this research a suggestion to further align this program with one of self-engagement and learning, one of peer mentorship and guidance and one of gaining both the knowledge of the areas uncovered in the category of 'understanding' and the sub categories and concepts outlined in this research. By asserting this level of engagement with RNs both the areas of applicable understanding can be further developed and through a mentorship or coach provision can then be explored, tried and refined in their application in practice. **It is recommended that the inclusion of the parameters of the understanding and the application be incorporated into existing and new leadership programs offered to RN in residential aged care settings.**

Through further research a greater understanding of the best approach to clinical leadership in practice in the residential aged care setting can be established. The recommendations provide the baseline or starting point to informing both organisations and RNs of the importance of RN led leadership. To firstly know the required areas and to secondly be able to perform these was a determinant in the role of the RN. Leadership programs seem determined to enhance personal characteristics of an individual in the quest to enlighten and empower the person in their leadership capacity and capability. **A recommendation is made that it is time**

to acknowledge the reality that work is required on systems in the residential sector that provide greater autonomy to the RN role and to further refine the definition of clinical leadership in this setting. This acknowledgement is part of a quest to minimise control and domination from organisational and political spheres that currently disempower individuals and inhibit RN leadership in the residential aged care setting.

10.5 IMPLICATIONS FOR THE RN

The essence of the voices of the clinical care staff has identified the need in the leadership role of the RN to be the responsible and accountable entity, to know when to be present and when to act and to articulate these areas into the governance roles in residential aged care nursing. It was this responsibility and accountability that provided the background in the operational guidance in care for residents and it was this notion that identified the leadership role as the interlinked component that brought together the care, the staff and the resident. This interlinked component often felt or seen as a presence and visualised by staff as a dependence on the RN, the reliability that the decision making required would occur or that the education needed would be provided. However, this essence of what staff sought did not prevail in all situations. It was this concept of an apparent discord in the system that appeared. It was understood in the sector that the nursing role of the RNs involved the coordination of UHCWs, EENs, allied health visiting personnel and usually numerous visiting medical officers (Jacob et al., 2013; Milson-Hawke & Higgins, 2003). External to the interdisciplinary group were families, carers, loved ones and government agencies. At each point of discussion the centrality of involvement remained with the resident, however at each point of discussion the central juncture was in the communication heard, understood and acted on by the RN.

It was the difference or indifference seen, heard and expressed through the clinical care staff participants that created the dissonance or consonance in the setting. The outcome at times was a multidimensional phenomenon, described on many levels and through a variety of layers. This complexity combined with what was discussed as the discord in transaction. It was the experience of the RN that appeared, a synopsis found in individual differences in the scope of the RNs, the individual practitioner and the variations in knowledge, skill and experience that

came to the fore. This discord was seen in the disparity among the RNs with the role seemingly caught between caring for residents and the quality trail of compliance from a more corporate governance viewpoint.

A commonality in thread in some respects was seen in the teamwork, the communication and the influence of the leadership role on the staff either individually or within the team. The discord in and between clinical care staff in the power balance with informal alliances and power differentials noted. This discord resulted in care completed in settings on an organisationally culturally accepted premise rather than by best practice standards or from within a practitioner's scope of practice requirements. The noted divide was in staffing groups from EENs to RNs to the increasing resource from the UHCWs. These roles, and the delineation of roles, were a complexity in defining the leadership role of the RN in residential aged care settings.

Through the voices of clinical care staff in aged care, this research has explicitly identified the domains that restrict and disempower the RNs ability to lead and perform. The commonality of power and influence and reform and regulation in both the domains of understanding and application of leadership create recognition that the RN is working in a complex domain-led environment, governed and mandated by structures of power, alliances and influencing forces in an environment of restriction, control and reform. This sub category of reform is cognisant of the ongoing evolution of providing what is deemed as safe and competent care from a regulatory perspective, yet restrictive in its true sense of allowing the ability of the RN to know, act and perform to the competency standards prevailing within the registration standards of an RN in Australia.

The orchestration of the leadership role of the RN has been presented. The realms and complexities of the role of the RN in the residential aged care setting has been outlined and interpreted from within a paradigm of hermeneutic phenomenological analysis. The story that has evolved is one of the people, their influence in the care provided, and in the influence and power exerted or perceived to exert that complemented further the team making capacity of the individuals employed in the residential aged care setting. These concepts individually and collectively align together, and are incorporated in the changing world of the aged

care industry. This change and alignment occurring all at a time when regulation and governance are key and the role and accountability of the leadership of the RN remains under greater pressure to perform and meet required standards of practice.

10.6 IMPLICATIONS FOR THE RESIDENTIAL AGED CARE SECTOR

The implications for the residential aged care sector is seen in the leadership enacted by the RN, the missed opportunities or the capacity of the RNs employed in the sector to both have a voice, an understanding and an ability to practically apply the leadership required. This leadership involves providing care to those as they age, to knowing intuitively through education, the conditions and care requirements and the ability to communicate more broadly in the health care team when concerns and issues arise. Importantly the outcomes gained from engaging the clinical care staff have enabled the voice of the staff including the RN to be heard, and to be understood from the perspective of the RNs leadership in practice. This leadership remains a critical component in the day to day operations of a residential aged care facility and a key component in the cost and budget implications for a residential aged care setting.

It is timely to hear and listen to the voices of the clinical care staff, and to act on these voices. The cost of implementing strategies upfront potentially creates savings in the long term through positive recruitment strategies and the retention of satisfied employees in practice. Those in management or formal leadership positions need to consider closely the outcomes of the voices of the clinical care staff and of the RN and the aged care team. **It is timely to engage the RN in the planning, implementation and evaluation of initiatives and hear from the RN in more strategic planning ventures.** Importantly the RN must be given a voice and have the capacity to enact initiatives in alignment with strategic direction and national scope of practice parameters. To achieve this **the RN requires the resources and the capacity to lead through a clinical leadership approach in collaboration with the broader health and social care team.**

10.7 STRENGTHS AND LIMITATIONS

The limitations of the research appear in the small sample size utilised to gain greater meaning and understanding to the leadership role of the RN. The aim of the research was to gain understanding of the leadership role of the RN. This construct derived from within the narratives of thirteen (13) participants. The process engaged numerous hours of transcribed narratives to achieve a depth of understanding from an interpretative lens.

Member checking was utilised in Section 5.8 to ensure the quality of data collected portrayed the information the participant intended. There is debate on the use of member checking at this stage however the process was completed to ensure the responses received from participants was accurate. This step also allowed for participants to provide further information. Participants that chose to provide further information did so through the sharing of a now remembered anecdote.

The key constructs emerged in the analysis as a twofold process in the leadership role of the RN. The limited sample size relevant to the number of workers in the aged care industry is noted. The outcomes provided are of a qualitative perspective and further research is required to link and combine these categories with the statistical evidence available on aged care nursing education, recruitment and retention data.

Limitations are noted in the small selection of facilities utilised, with only four (4) sites across Queensland and South Australia selected. Homogeneity was addressed by the determination of research sites. To gain more than one organisations perspective two overarching organisations were chosen across two different states in Australia. The selection of sites albeit diverse in their representation, remains as only a small sample in the broader industry perspective in Australia.

10.8 RECOMMENDATIONS FOR FURTHER RESEARCH

More innovative concepts in aged care nursing are required. Such areas have been heard from the clinical care staff engaged with the RN in care provision relating to the communication in and within teams, to external health care professionals and with families. It would be anticipated that this more proactive approach to resident centred care management would provide in the long term better chronic disease management, less time on acute exacerbations and after hours liaison, and a more focussed approach in leading the team from the RN. A more focussed approach as the reactive management required in the current system has according to this research left the RN stretched to one of problem solver and manager of problems. This is in contrast to the holistic notion that the nature of the role entails.

The RN requires education for leadership in practice, rather than leadership by style or characteristic. Clinical leadership has been identified as a key component in the understanding and application of leadership by the RN in the residential aged care setting. This clinical leadership by definition is not completely clear however the findings from this research have identified the key attributes that the voices of clinical care staff have identified as the beginning definition of the leadership role seen. The definition outlines the key parameters inherent in clinical leadership in residential aged care nursing.

Clarity has been gained from the findings that the leadership role required of the RN is one of both an understanding and an application or in other terms a science and an art. These concepts represent the ability of the RN to have the knowledge and skill but to also have the presence, the innate being of security and the knowing and understanding to act on care and decisions in the residential aged care setting. It is a complex ability that requires greater exploration within the residential aged care setting.

The dependence and reliability of staff on the role of the RN created an informal leadership, one of a presence, a being in the clinical domain of care and care decisions. The literature discussed clinical leadership as seen by the RN in a clinical setting in the utilisation of decision making capacity in line with clinical needs, staff relations, and organisational capacity (Castle & Decker, 2011; Cummings et al.,

2010; Stanley, 2014). The research affirms aspects of this definition in the leadership role seen in the residential aged care setting. The RN in residential aged care is critical in fostering the required collaborative relationships with aged care staff.

Clinical leadership was further identified in the leadership role of the RN in maintaining the legislative and governing requirements in the setting. The leadership role of the RN was intrinsic to the monitoring of compliance within aged care standards and furthermore intrinsic to the care planning requirement of residents. In knowing the people the relationships were intricately balanced to achieve resident outcomes and to gather the required data through audits and compliance studies to meet these standards. This high degree of regulation, audit and compliance was supported through the literature (Angus & Nay, 2003; DoHA, 2006; Hugo et al., 2009).

Knowing the people was intricately linked to the role of mediator; it was the RN that provided the levelling of situations, of dynamics, the education of staff and of a personal sense of well-being in the work environment. The focus on education and training was a key area noted particularly with high staffing ratios of UHCWs. Ongoing education and training is provided to ensure compliance to standards is maintained and that care is completed to the level or expectation of the RN. **It is recommended that the construct of clinical leadership in residential aged care be further explored in light of the concepts found in this research**.

Further **it is recommended that research into the specific trends and occurrences in the residential aged care nursing domain respectively relating to what takes the time in the RN leadership role would be beneficial**. It is in understanding the areas of care delivery, coordination, human resource and interpersonal relations that further knowledge and improvements can occur that look specifically at role improvements to enhance and provide more time for caring from the role of the RN in leading the team.

10.9 CONCLUSION

The leadership role of the RN has been defined, outlined and discussed. The complexities have been noted, the dissonance and consonance of what does and does not work have been identified and the performance has been found, and heard. The research has uncovered a quality that objectively cannot be described in its completeness however it is a quality in the leadership role of the RN that has definitive links with the concepts of clinical leadership and a distributed leadership approach. This combined juncture is viewed as a clinical leadership encompassing a shared learning and inclusive approach to decision making.

It is a leadership seen, heard and enacted in the realms of providing clinical care and decision making in and within teams of staff. Both the understanding of the leadership role and the application of leadership in practice are required to enable the desired RN clinical leadership in the residential aged care setting. When aligned the understanding and the application of the leadership role creates a sense of clinical leadership.

The 'application' of the leadership role was seen from the leading and following, the trust and respect and the power and influence in care and care decision making. Correspondingly the passion and care expressed and provided by staff in the provision of care requirements was also heard. The reform and restrictions created further complexities to the leadership role of the RN in the environment from both an understanding and an application perspective. The leadership role of the RN was identified as a fine balance between the leading, sometimes following and at other times the silent observer available and willing to intervene or converse when the time was seen as right.

There are a number of excerpts that related to these concepts, all of which relate to the interconnectedness observed. This interconnectedness similar in nature and context to the conductor of an orchestra and the coordination of all concepts in the creation of music. The RN in the setting has the knowledge, establishes the lead, and shares the subtleties of the 'application' of the leadership role overtly and covertly with staff. Notwithstanding, this leadership occurs in a structure where a hierarchy of control exists. It is in this context that the RN leadership requires the

succinct coordination of activities in the day to day operation of caring for those residing in a residential aged care setting.

This leadership is seen in the linking of activities further to the broader strategic motivations or financial or physical resourcing requirements of a setting, the accreditation standards, staffing, families and a care specialisation not formally recognised in the role. The RN leadership is encapsulated in the coordination and support provided in all these activities in residential aged care settings in Australia, that is the day to day clinical leadership of the RN in the residential aged care setting.

The articulation of the interconnectedness of the categories of understanding of the leadership position and the application of leadership in practice create the concepts required in the definition of the leadership role. The exploration of the voices of aged care staff in residential aged care settings has identified a complex process involving the need to have the knowledge and understanding of the concepts identified in the leadership role and the ability to apply these in the application of leadership in practice. Leadership as defined by the clinical care staff in the residential aged care setting encompassed the feelings, emotions and the presence of the RN in the setting and equated to the words of Wheatley (1993, p. 44), who quite eloquently stated '*music comes from something we cannot direct, from a unified whole created among the players—a relational holism that transcends separateness'*. It was the analysis and description of the 'what is' that captured the insight into the complex world of RN leadership in the residential aged care setting.

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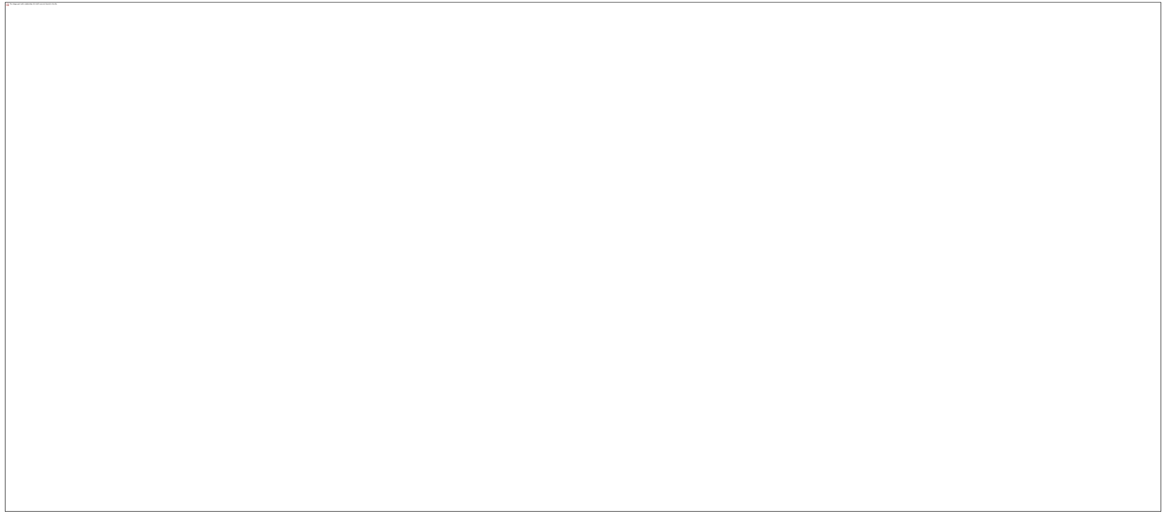
Appendices

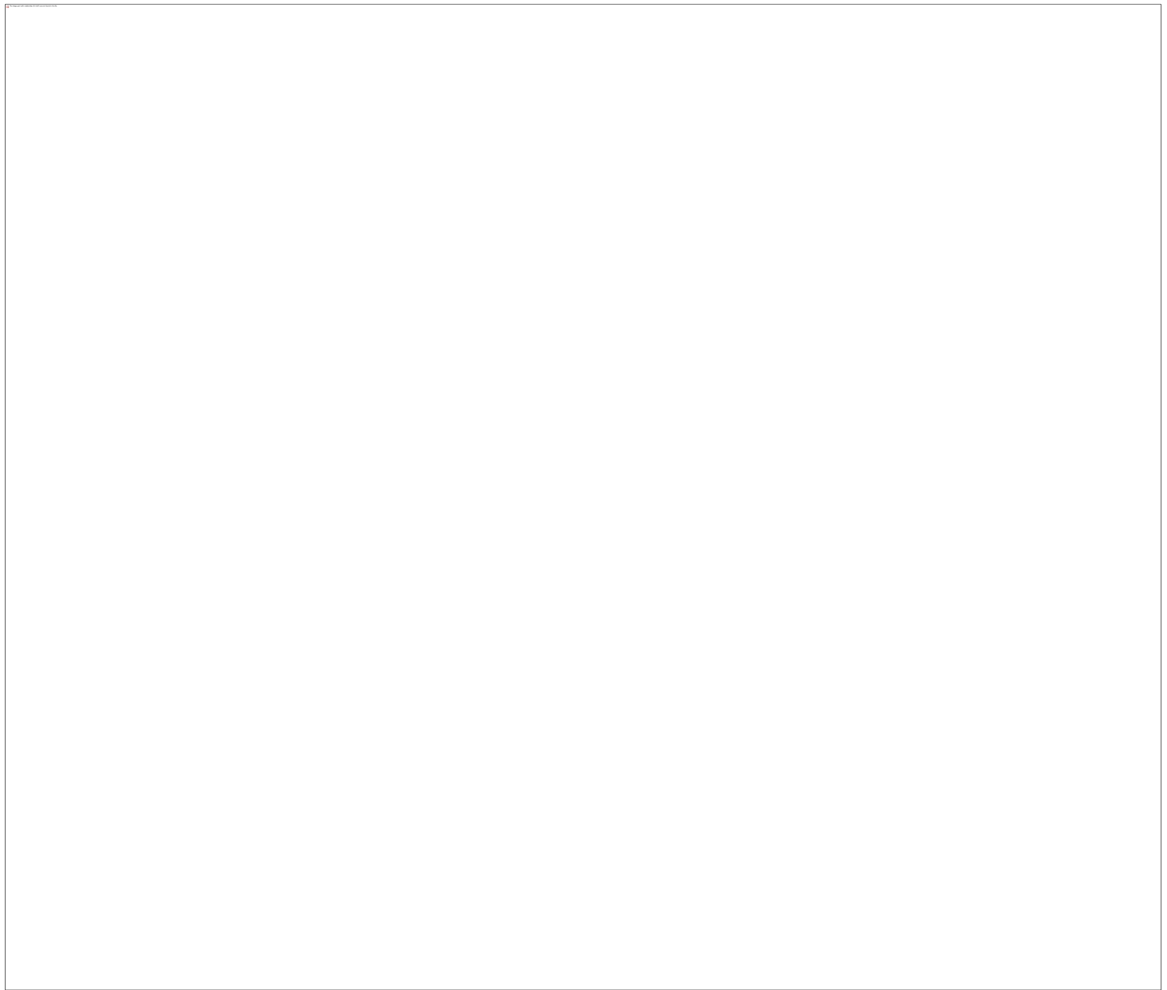
Appendix A

Ethics approval University of Southern Queensland



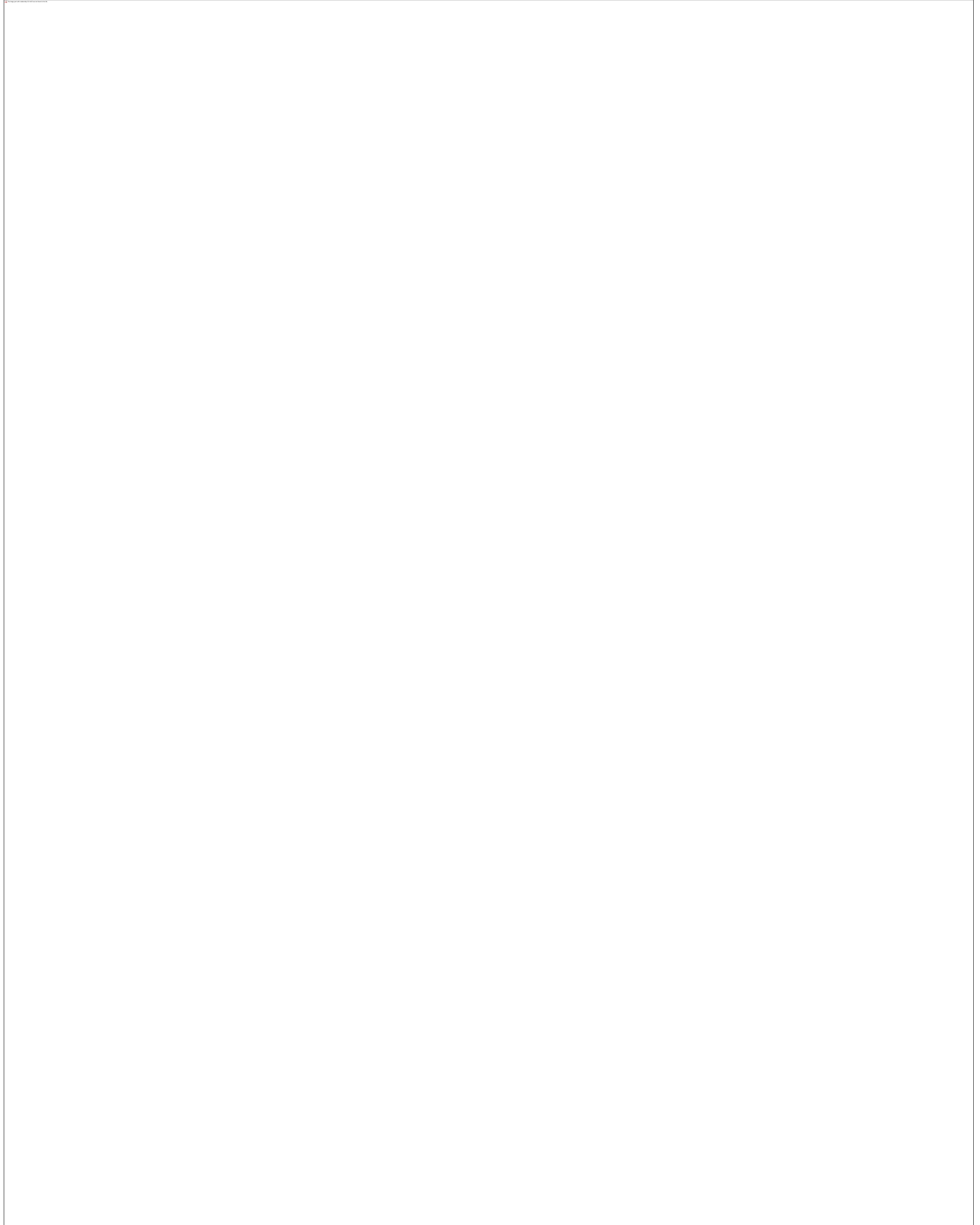
Appendix B

Participant Information Sheet



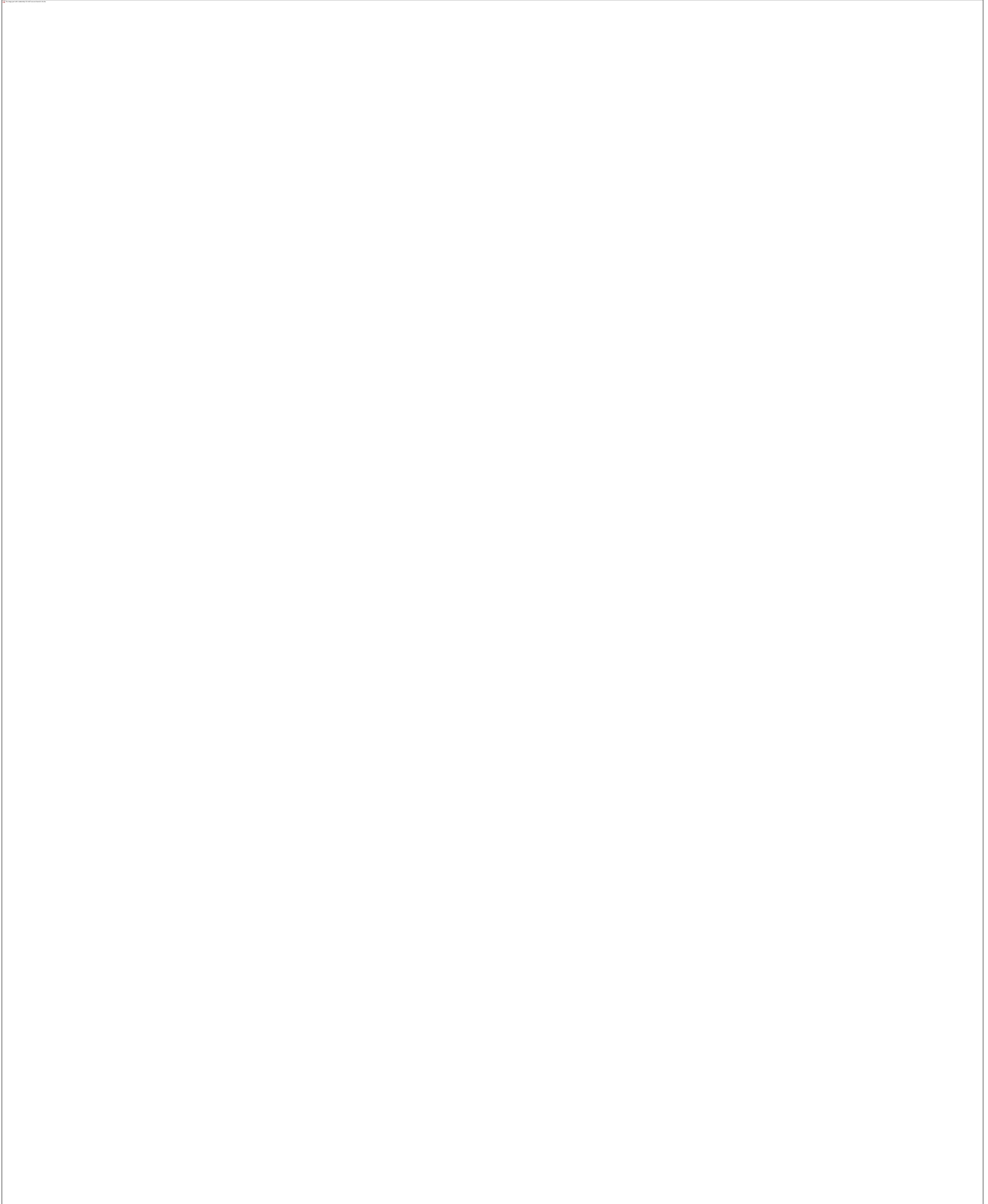
Appendix C

Research Consent Form



Appendix D

Letters of Invitation



Appendix E

Interview Questions

General Instruction:

Prior commencement of the interview the following discussion will occur with the participant:

- Welcome and recognise participant participation
- Provide overview of the research project
- Provide participant with information sheet, explain consent process
- Re-emphasise need to digitally record session for accurate transcription
- Give time for addressing questions from participant minimum 10 mins.
- Consent form to be completed and retained by researcher.

Interview Questions

To gain a greater understanding of the types of individuals working within aged care the interview will commence with a couple of individual background related questions

1. To start the interview can you please tell me what your role is in the organisation? How long have you worked here?

   Have you worked within aged care sector before this position with Anglicare? If so, what was your previous experience like?

2. The registered nurse role has responsibilities within registration and employment standards that pertain to their (RN) capacity to lead a team, be central to resident assessment, provide key decision making and health care decisions, and converse with family and staff in key communications. I would like you to tell me your story of working with registered nurses in your workplace. In your story tell me how care and decisions about care occur.

   Possible cue – you mentioned.....can you tell me more about this?
   Possible cue – your mentioned.....can you share more of this aspect (**) of the story with me?

3. Can you tell me about how the registered nurses role works in your organisation? Take your time and share all the aspects that you regard as
   a. important,
   b. what works,
   c. what improvements you can identify,
   d. what challenges you see?

   Possible cue – you mentioned.....can you tell me more about this?
   Possible cue – your mentioned.....can you share more of this story with me?

4. Can you think of times in the workplace where the registered nurse role showed great leadership within the team? Can you tell me about this?

   Possible cue - Why was it so positive?
   Possible cue – you mentioned.....can you tell me more about this?
   Possible cue – you mentioned.....can you share more of this story with me?

5. Given each day is about caring for the residents here, can you share your impression or a story of how you think a resident would view the role of the registered nurse in this organisation.

Possible cue – you mentioned.....can you tell me more about this?
Possible cue – you mentioned.....can you share more of this story with me?

6. Share an experience of how you/registered nurse would lead the care for a resident

Possible cue – you mentioned.....can you tell me more about this?
Possible cue – you mentioned.....can you share more of this story with me?
Possible cue – Can you share more about what improvements you think could happen?
Possible cue – Can you share more about the impact on staffing…
Possible cue – Can you share your experience of the barriers/ successors in providing the right care

7. There are many influences within the workplace. Some make our roles easier and some pose barriers. Can you tell me about what influences the registered nurse role to lead in the aged care environment?

Possible cue – Can you tell me about any organisational barriers / personal / policy / others that may have an influence.
Possible cue – you mentioned.....can you tell me more about this?
Possible cue – your mentioned.....can you share more of this story with me?

Closing

- Thank the participant
- Explain again how the information will be used.
- Provide participant with summary of how the project information will be disseminated